Meaning and Meaninglessness in Neuropsychiatry

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MD THESIS IN MEDICAL HUMANITIES

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CONTENTS

STATEMENT

I can confirm that this thesis is entirely my own work completed for the purpose of obtaining a Medical Doctorate (Research) degree from King's College London. I received bi-monthly supervision from my primary and secondary supervisors, Professors Derek Bolton and Michael Kopelman respectively, over the three years during which the research was conducted. In order to conduct the Interpretative Phenomenological Analysis component of the research I attended basic and advanced training workshops run by Aston University, Birmingham. I can confirm that the contents or parts thereof have not been submitted for any degree other than the MD (Res) stated above. Brief sections of the *Discussion* chapter have been included in a chapter that I co-wrote with Professor Derek Bolton on philosophy and neuropsychiatry for the forthcoming *Oxford Textbook of Neuropsychiatry*.

ABSTRACT

Psychiatry relies upon semantic and epistemological concepts in characterising psychopathology as meaningful or meaningless, rational or irrational. These in turn are used to distinguish between the normal and the abnormal as definitions of mental disorder often invoke meaninglessness as a hallmark of dysfunction or neurological damage. Despite this reliance the analysis of such concepts within psychiatry is minimal; clinicians and carers instead relying on common sense intuitions. Detailed study of semantic and epistemological concepts belongs primarily to philosophy with Karl Jaspers descriptive psychopathology the major psychiatric contribution to the topic. Over the course of the Twentieth Century theories of meaning have been developed within philosophy oftentimes utilising the psychopathological as boundary cases. Neuropsychiatric phenomena, alleged to straddle the neurology/psychiatry divide, may represent boundary cases between the meaningful and meaningless. The aim of the current study is to therefore to investigate whether the meaningfulness of neuropsychiatric phenomena does falter or even fail and, if so, to explore some of the implications for psychiatry. How to conduct such an investigation, however, is unclear. Interpretative Phenomenological Analysis (IPA) was chosen as a robust qualitative methodology to conduct and analyse interviews exploring what patients and their carers understood of neuropsychiatric symptoms (the primary analysis). An additional attraction of IPA is the ability to apply hypotheses formalised from other theoretical domains, such as philosophy, to the interview material (secondary analysis). Patients with classical neuropsychiatric (confabulation, visual hallucinations, misidentification syndrome) symptoms were recruited from two London teaching hospitals. The interviews underwent primary analysis to discover relevant themes and issues with regards meaning of the symptoms. There was then a secondary analysis utilising the theories of meaning developed by Daniel Dennett, Donald Davidson, and Ludwig Wittgenstein. The outcomes of the analyses are presented separately as results parts A & B. The patient and carer interviews demonstrated that the meaning of symptoms becomes increasingly contested but is not revoked. For carers, neuropsychiatric symptoms simultaneously signify disease and symbolise distress. While Dennett's intentional stance does indeed falter when interpreting the symptoms his reductive consequences fail to follow. Davidson's and Wittgenstein's approaches are more preserving of meaning and enable us to see that a scientific neuropsychiatry cannot abandon meaning.

INTRODUCTION

AIMS AND PURPOSE OF THE THESIS

A recurring problem in psychiatry is the meaningfulness, or otherwise, of psychiatric symptoms. Critics of psychiatry have at times accused the discipline of misconstruing mental phenomena and behaviour, including the verbal sort, as symptoms, in accord with other medical specialisms. This, the critics argue, strips the phenomena of meaning, just as the brief shock-like involuntary myoclonic jerk is taken by neurologists to mean nothing beyond signalling pathology of the nervous system. If symptoms are meaningless then content can be ignored; the neuropsychiatrist German Berrios, for instance, infamously described delusions as "empty speech acts."[1] This, however, entails a silencing of the patient and diminution of their agency, grave insinuations in an era that valorises autonomy and individuality.

Neuropsychiatric symptoms are severe psychiatric phenomena closely associated with established neurological disease and so, one might suppose, resemble neurological symptoms proper, such as the myoclonic jerk. If, on the other hand, neuropsychiatric symptoms convey meaning this is likely to generalise to other psychiatric symptoms. The aim of the current study is to investigate whether and how the meaningfulness of neuropsychiatric phenomena does falter or even fail and, if so, to explore some of the implications for psychiatry. It is not at all obvious, however, how to conduct such an investigation. What are the criteria by which meaningfulness can be judged and who is best placed to do so?

Meaning became a major philosophical topic in the 20th Century and a number of philosophers offered more or less explicit accounts of it. Nevertheless, no philosophical theory can be considered gold standard given they tend to be conceptual and rarely, if ever, put to empirical test. Indeed, such a test presupposes the conclusion because the meaningfulness or otherwise of the entity under investigation must be established prior to the study. The theory is therefore judged against our pre-theoretical intuitions. This will tell us little about the boundary cases that interest us here, as it precisely these intuitions that

we seek to investigate. The best that can be offered is to hold the neuropsychiatric phenomena alongside philosophical theories of meaning in order that each might throw some light upon the other: how do neuropsychiatric symptoms appear from a theory of meaning and are these boundary cases anticipated or accounted for by the theory? We aim for mutual illumination and reciprocal clarification.

The remainder of this introductory chapter describes the broader context of the study question. First we revisit Karl Jaspers' exemplary discussion of meaning and meaninglessness and some contemporary responses. This provides an overview of the dispute and offers a rationale for looking specifically at neuropsychiatric symptoms. The focus then shifts to instances where the meaningfulness of these has been debated. Key points in such debates will be made apparent. Next, we examine the issue of meaning as a boundary for mental disorder. This is important because psychiatry has difficulty drawing a clear border around its domain. If some phenomena are meaningless this could perhaps function as a limit, a topic to be revisited in the final discussion. The introduction is concluded by an outline of the three philosophies of meaning that will be investigated, what unites them, and why they have been selected.

The methodology chapter commences with a review of methods by which meaning has previously been explored in relation to psychopathology, culminating in a justification for and description of Interpretative Phenomenological Analysis (IPA) the method employed here. This involves in-depth semi-structured interviews with patients and their carers about the significance for them of their prototypical neuropsychiatric symptoms. After the methods chapter we sequentially examine the three philosophies of meaning, concluding with a section that highlights key hypotheses to be explored in the study. There is then a discussion of meaning's role in existing models for each neuropsychiatric symptom: Capgras' delusion, visual hallucination, confabulation. The results are presented in two separate sections. The standard IPA analyses of the interviews are presented first, followed by the secondary analyses, which integrate the theories of meaning with qualitative interview material. It is important to bear in mind throughout the thesis that contrary to standard IPA practice it is this secondary analysis that forms the most significant portion of the research. This deviation from usual practice is warranted because the examination of meaning and meaninglessness is a novel undertaking without clear precedent, as the review of

methodologies demonstrates. The implications and limitations of the results are presented in the final discussion section.

JASPERS AND UN-UNDERSTANDABILITY

In *General Psychopathology*[2] (*GP*) and *The Phenomenological Approach in Psychopathology*[3] the philosopher psychiatrist Karl Jaspers explained that many mental symptoms are understandable, through the empathic method, which he described in some detail. First, he divided symptoms into objective and subjective types. The former are comprised of "all concrete events that can be perceived by the senses, e.g. reflexes,"[4] and the like. Myoclonic jerks would fit in well here. More idiosyncratically, also considered objective were "the rational contents of what the patient tells us." [5] Specifically, "thoughts may be understandable because they emerge from each other according to the rules of logic."[6] Rationality was for Jaspers so undisputed that he neglected to specify it further. Yet it enables one to "understand what is said,"[7] which contrasts with empathic understanding,[8] the mode of access for the phenomenological characterisation of mental states, that is: "the representation, description, definition, differentiation, and classification of individual psychic experience."[9] This is gained via the patient's self-descriptions. Crucially, however, the genetic understanding of non-rational connections between mental states is also achieved through the means of empathy. This empathic understanding was for Jaspers an effortless apperception, requiring the transferal of oneself into the other's situation.

> We understand other people, not through considering and analysing their mental life, but by living with them in the context of events, actions and personal destinies…. [The psychiatrist] can share the patient's experiences – always provided this happens spontaneously without his having to take thought over it. In this way he can gain an essentially personal, indefinable and direct understanding, which, however, remains for him a matter of pure experience, not of explicit knowledge.[10]

Genetic understanding is self-evident but this does not confer validity. Its veracity rests instead, "*on the tangible facts* (that is, on the verbal contents, cultural factors, people's acts, ways of life, and expressive gestures) in terms of which the connection is understood, and

which provides the objective data."[11] As the objective data is rarely complete one's empathic understanding must necessarily remain merely an interpretation, however. Jaspers' notion of empathy is ambiguous on whether one's empathic understanding of another is achieved directly, as intimated in the long quote above, or indirectly by observing the physical manifestations of the mental state (e.g. the physical expressions of anger or fear.) Some[12] see a tension here while others[13] conceive them as inseparably bound – directly perceived actions and expressions are evidence for the indirectly understood mental life. Furthermore, assertions that empathy is spontaneous and effortless are belied by the need for "transferring oneself, so to say, into the other individual's psyche" and the requirement "to train ourselves in it and master it" while psychiatrists "unwilling or incapable of actualizing psychic events and representing them vividly"[14] lack empathic understanding of their charges. It seems therefore that the psychiatrist actively chooses the empathic approach by engaging with the patient and having done so the understanding occurs automatically without effort. Empathic understanding is not driven by any theory; it is in fact opposed to theorising. For instance, Jaspers was critical of psychoanalysis for imposing theory on all mental symptoms: "They have thus come to 'understand' almost all the contents of these psychoses by applying a procedure which as the results show only leads on to endlessness."[15] Instead, he asserted that certain psychiatric phenomena are fundamentally un-understandable. For Jaspers there are three gradations of understanding.[16] The first are those psychic events that everyone empathically understands as emerging meaningfully, as described above. To the intermediate group belong psychopathological experiences that are exaggerations, diminutions or combinations of normal mental states. For example, arachnophobia is an exaggerated anxiety response but one which we all understand in terms of the trigger and the sufferer's response.

> The third group of pathological phenomena are distinguished from the two previous groups by their complete inaccessibility to any empathic understanding. We can only get closer to them by means of analogy and metaphors. We perceive them individually, not through any positive understanding of them, but through the shock which the course of our comprehension receives in the face of the incomprehensible.[17]

Un-understandability can afflict both static and genetic empathy. For the former it is an inability to directly access the other's mental state while in the latter it emerges *de novo*, as

if from nowhere, rather than emerging understandably from personal context or cultural history. Jaspers speculated that here purely biological causal processes were at work. While "symptoms that occur in neurological disease and schizophrenia are equally un-understandable it is of an entirely different order:

> In the one case it is as if an axe had demolished a piece of clockwork – and crude destructions are of relatively little interest. In the other it is as if the clockwork keeps going wrong, stops and then runs again… the schizophrenic life is peculiarly productive.[18]

Although neuropsychiatric phenomena would be expected to lie outside our empathic understanding Jaspers nevertheless counselled against an over-readiness to ascribe un-understandability, warning that the fault may lie with the clinician's ability to comprehend: "In the case of every investigator it is a matter of his human stature as to what he understands and how far his understanding reaches."[19] How then are we to know that the seemingly un-understandable is not the limited empathy of the clinician or indeed a difference in the sources of her understanding?

Jaspers has remained something of a bogeyman in the psychological literature on meaning in mental disorder. Richard Bentall, for example, takes Jaspers to task in *Madness Explained*[20] for handing psychosis to the biologists and negating the need for clinicians to relate humanely to their patients. Delusions, he says, can be understood as arising by distortion of normal belief formation processes. They are not distinctive phenomena but instead lie on a continuum with "normal" belief. Jasperian un-understandability is directly challenged by the phenomenologically orientated psychologist Louis Sass in *The Paradoxes of Delusion*.[21] He seeks to understand the bizarre and seemingly incomprehensible through a close reading of Daniel Paul Schreber's fantastical *Memoirs of my Mental Illness*. Schreber was a high court judge diagnosed with schizophrenia and detained involuntarily for many years. Freud famously attempted an analysis of this text, but it is perhaps worth noting that Sass traduces both psychoanalytic and antipsychiatry conceptualisations of delusion. Each regards delusion as a primitive or regressed state where "unmodulated desires and the wild meanderings of primary-process thought overwhelm logic, the capacity of reflective distance from experience, and all sense of realism and social convention,"[22] disparaged by the former

but valorised by the latter. Sass argues here and elsewhere[23, 24, 25] that much of the seeming heterogeneity and ambiguity of symptoms in schizophrenia can be understood as stemming from, what he calls, ipseity disturbance. This is the tendency for hyper-reflexivity (experiencing the self as external object) and reduced auto-affection (a diminishment in the vitality of one's own subjective self-presence), which produces a mental attitude akin to the philosophical doctrine solipsism. By remaining passive, observing and concentrating on one's own thoughts, Sass declares: "At this point a person can be said to experience *experience* rather than the world, to have the impression of seeing, say, not an actual and physical stove but a 'visual' stove, the stove-as-seen-by-me."[26] The quasi-solipsistic delusional world is preferred over the real world, for it evades the anxiety of experiencing the limitations of one's actual knowledge and power, although the solipsistic experience does foster anxiety due to its instability. By providing an account of Schreber's reported experiences and the apparent ambiguities in terms of a seductive but ultimately unstable philosophical position, Sass feels he has, *contra* Jaspers, understood the seemingly incomprehensible.[*] For Sass, the content of the delusions arise as a means to explain the fundamentally changed *form* of experience. Sass claims there is a tendency "particularly among organic psychiatrists… to ignore the psychological interpretation or empathic understanding of mental symptoms."[27] This tendency is, Sass says, nurtured by the development of neuroimaging and somatic markers of disease, but its roots predate them. Psychiatrists and neurologists, inspired by such icons as J. Hughlings Jackson, view mental symptoms as mere defects or deficiency secondary to cerebral disease. Sass thinks though that psychiatrists have the cart before the horse. Psychopathological phenomena are regarded as meaningless because they are first assumed to be symptoms of underlying disease, as opposed to first finding no reason for the person's experiences and then attributing this finding to disorder. While his argument is primarily addressed to schizophrenia, it is equally applicable to neuropsychiatric symptoms

[*] This is not Sass's only attempt to understand Schreber's lived experience from a philosophical perspective. He has also attempted a Foucaldian formulation whereby Schreber's famously pedagogical father is accused of setting up an almost perfect system of continual observation to ensure his son's proper psychological development. However, rather than contradicting his Wittgensteinian approach, it supports his overarching argument that the symptoms of schizophrenia reflect an "objectifying detachment" that can ultimately be understood as meaningful.

and disorders because the phenomenologist understands every insult, whether psychological or organic, to invoke a personally meaningful response.

This brief overview of Jaspers' position and some influential responses to it brings out a number of points pertinent to the study. Despite Jaspers lengthy descriptions of his empathic method it remained seriously underspecified: how exactly does one transfer oneself into another's "psyche" and is intuitive interpretation in the absence of theory even possible? While he criticised Freudian psychologising as endless so too, it would seem, are empathic interpretations for the objective data are rarely, if ever, complete. Significantly for the current project, it is unclear whether an instance of un-understanding points to a failing in the observer or a truly un-understandable mental phenomenon; or even how to distinguish between the two possibilities. As shall find later, Jaspers' conception of rationality as of only marginal relevance to understanding is unusual. Implicit in Bentall's argument is a logic similar to Jaspers; if delusions are really beyond understanding then they will correctly fall within the domain of biology and neurology. It is with regard to the interpretability of delusions that he rebukes Jaspers, not the soundness of the understandable/un-understandable distinction. Sass on the other hand retains a place for meaning in neuropsychiatric disease as a coherent and meaningful response to the neurological injury and worries that neuropsychiatrically inclined doctors systematically neglect its significance. Neuropsychiatric phenomena are therefore likely to represent boundary cases between the meaningful and meaningless hence merit further investigation. Sadly, however, Jaspers' empathic method begs more questions than it addresses and is too poorly specified to assist our investigation further. Before moving on to questions of method let us review some instances in the literature where the meaningfulness of neuropsychiatric phenomena have been discussed, starting with Freud's discussion of Dostoyevsky's seizures and then the Capgras delusion.

CLASSIC AND CONTEMPORARY NEUROPSYCHIATRIC CASES

Freud's account of Dostoyevsky's "so-called epilepsy"[28] points to the danger of over-interpretation raised by Jaspers. Dostoyevsky's seizures were linked to the murder of his father, indicating to Freud an unresolved Oedipal conflict. The affect-laden trance-like states

that occurred during Dostoyevsky's childhood were said to symbolise an unacknowledged wish for his father's death, which every lad must navigate. He wished to kill and then replace the father in his mother's affections, so experienced himself *as* the dead father. After his father's actual murder Dostoyevsky developed, in Freud's words, "hystero-epilepsy." This rendered him morose and guilt-ridden after each seizure, proving the adage to be careful what you wish for. Others have used Dostoyevsky's own written accounts of his seizures;[29, 30] the description of seizures afflicting some of his own characters;[31, 32] and third-party testimony[33] to construct a profoundly different hypothesis. Most, though not all,[34, 35] retrospectively diagnose Dostoyevsky with mesial-temporal lobe seizures that produced psychic auras and post-ictal states suffused with affect and portent. Where Freud perceived hidden meanings, others see brute biological cause and effect.

Capgras syndrome is a delusional state in which the sufferer believes someone close to him or her has been replaced by an imposter, identical in appearance. Although there are occasional cases where the sufferer goes to great length to prove the veracity of his claims – for example, the tragic case of a young man who decapitated his father in order to locate the batteries powering the robotic *alius*[36] – most who experience this delusion continue to co-exist quite peaceably with the supposed impersonator.[37] The intimate nature of the double seems to cry out for psychological interpretation and very many have been proposed.[38] A favourite of the psychodynamic accounts holds that the delusion is a solution to ambivalence towards the impersonated person; it allows the guilt-free expression of repressed hate by transferring it onto another 'object', while the good and real object is absent. Thus, there is splitting and projection of the hateful feelings onto the imposter that can now be overt.[39] Following the observation that the Capgras delusion is particularly common in those with neurological disorders[40] and it is not exclusive for intimates or even animates[41] an alternative neurobiological theory has gained traction over the last two decades. Stone and Young have introduced the basic methodological principles of cognitive neuropsychology[42] to the study of psychiatric symptoms, including the Capgras delusion.[43, 44] First, they contrast the delusion with a symptom familiar in the neuropsychological literature, prosopagnosia. Those suffering with prosopagnosia have a specific deficit on recognition for faces. Prosopagnostics, however, continue to exhibit autonomic arousal selective for faces familiar to them, as measured by the galvanic skin conduction test, suggesting a degree of recognition at a subconscious stage of visual processing.[45] This, it is

alleged, is an affective component of recognition instantiated by the dorsal stream and distinct from the ventral streams processing of visual features.[46] The suggestion is that those suffering the Capgras delusion recognize that the facial features are the same as their relative's in the absence of the customary emotional salience. This unexpected experience requires some sort of explanation. It is alleged that the belief their relative is being impersonated neatly resolves the paradoxical experience of recognition/non-recognition. As with Dostoyevsky's seizures, interpretation of the symptom as symbolic of interpersonal conflict contrasts with theories of neurobiological deficit and malfunction.

The two outlines presented above illustrate that neuropsychiatric phenomena are contested in terms of their meaningfulness. Time now to uncover some features of these disputes. Most glaring are the similarities on each side. Both psychological and neurobiological accounts agree that *something* requires explanation. That is, the phenomena are readily distinguished from other mental and behavioural states hence require a special story to explain their presence; and the special story involves extra-conscious entities, whether repression of desires or dysfunctional dorsal visual stream information processing. Each type of account also recognises the same set of surface features and facts. It is their interpretation that is in dispute and the act of interpreting necessarily implies a theory or prism through which to interpret these features. There is no such thing as theory-neutral interpretation, *contra* Jaspers. Both types of account acknowledge the subjective sense of meaningfulness that occurs but each deprecates the actual significance they hold for the sufferer. Thus, however profound Dostoyevsky experienced his auras to be, he is unlikely to have considered their signifying patricidal desires. Also, meaningfulness or otherwise is not assessed directly but operates as a background assumption, an organising principle even, in each type of account.

In the next section we consider two contemporary positions on whether meaning should function as a boundary between disorder and non-disorder to further emphasise the importance of meaning to psychiatry. That section is followed by a brief discussion on the retreat of meaning within philosophy and psychology in the latter part of the 20th Century, a topic that will re-emerge in the discussion chapter.

MEANING AT THE BOUNDARY OF MENTAL DISORDER?

Although not directly concerned with the meaningful/meaninglessness distinction, it is ever just beneath the surface in Jerome Wakefield's work on the definition of disorder. Wakefield seeks to develop a robust conception of disorder[47] for practical and theoretical use by psychiatry, arguing that any viable definition must include both a value and factual component.[48] He proposes that disorder, when properly analysed, is a harmful evolutionary dysfunction. These two components provide individually necessary and jointly sufficient criteria for the presence of disorder. Dysfunction, a purely factual affair, is the failure of an internal mechanism to perform its selected function. But dysfunctions are not disorders unless they additionally cause some harm to befall the organism. This was all marginal stuff, curious but not exactly crucial, until the publication of *The Loss of Sadness*,[49] co-authored with Allan Horwitz. They allege that psychiatry has vastly over-extended the concept of depression to include what previously was understood by all to be unhappiness in response to the vagaries of life, which they consider normal sadness. The diagnosis of depression should be reserved only for those states that arise due to an evolutionary harmful dysfunction. As we do not have direct knowledge of the natural functions of the mind, the distinction between normality and disorder must be discerned from the context in which the symptoms arise. Normal sadness occurs "with experiences of loss or other painful circumstances," while:

> The other kind of condition, traditionally known as *melancholia*, or depression "without cause," was a medical disorder distinguished from normal sadness by the fact that the patient's symptoms occurred despite there being no appropriate reason for them in the patient's circumstances.[50]

Note, Wakefield and Horowitz are not simply restating the endogenous/reactive dichotomy in evolutionary terms. They remain agnostic on whether the dysfunction is physiological or not. They adhere to the modularity of mind thesis so the dysfunction could be in terms of information processing, "as malfunctions at the mental level of meanings."[51] Their criticism is that psychiatry now encompasses appropriate and meaningful states of unhappiness as disordered.

Another recent text in the philosophy of psychiatry is Derek Bolton's, *What is Mental Disorder?: An Essay in Philosophy, Science, and Values*.[52] Bolton here examines the various conceptions of mental disorder that have been proposed over the years: the social values-based model, medical-deficit model, and Wakefield's evolutionary approach. He detects "a question that presses on several fronts: is it possible to define mental disorder in terms of breakdown of meaningful connections?" [53] If so, all mental disorder is necessarily meaningless and the detection of meaning in a particular syndrome thereby entails its removal from the diagnostic manuals, which would result in their being pruned radically. This seems to be precisely what Wakefield advocates, but the psychologising trend within psychiatry over the past century would then be utterly undermined. Bolton wants to resist this and determines that meaning is often retained in mental disorder, if at times not immediately obvious.

> It is true that we begin to think of mental disorder when we fail to find normality and meaning of the kind we are used to, but the point at which this kind of normality are thought to run out is relative to what we are used to. Sometimes a closer look reveals more meaning, more normality, than we thought.
>
> The key point is that if the behaviour is maladaptive enough, if it causes enough harm, then the fact that it can be understood as meaningful… is not necessarily enough to exclude the attribution of disorder.[54]

Bolton's *Mind, Meaning, and Mental Disorder,*[55] co-authored with Jonathan Hill, also tackles this question but concludes that mental disorder can be a consequence of meanings being at odds with one another; not an absence of meaning but a clash. So in Bolton's work, meaninglessness is not a discriminator between disorder and non-disorder, but it acknowledges that meaning begins to falter and, implicitly, that some pathological mental states may be meaningless. However, Bolton acknowledges, like Jaspers, that the fault may lie with the interpreter so one should not be over ready to ascribe meaninglessness. This brief review of meaningfulness as a boundary for disorder should demonstrate its ongoing import to psychiatry and is a theme that will be picked up once again in the discussion section. Another theme that bears upon the thesis involves attacks upon human rationality and meaning from within psychology and philosophy. Such attacks undermine our capacity for self-knowledge of reasons for actions and decision-making capacity. If on the right track,

then the meaningfulness of all our claims might be thrown into doubt. It is to such arguments that we now turn.

THE RETREAT OF MEANING

Man may tend towards producing coherent and psychologically satisfying explanations for events even where these lay outside his ken. Consider the renowned experiments on callosotomy patients reported by Gazzaniga and colleagues over the years.[56] Split-brain patients were presented with conceptually unrelated visual images to each hemisphere exclusively. For instance, the right hemisphere was shown a snowy landscape while the left was presented with a hen's claw. The subject was shown another set of images, available to both hemispheres, and asked to point simultaneously with the left and right hand to the image most closely connected with the cue image. The right-hand points to the picture of a hen while the left-hand selects the spade. When asked to explain the reason for pointing to the spade the subject responds without hesitation something along the lines of, "the spade would be useful to clean out a hen-coop." The left hemisphere had no knowledge of why the spade had been chosen by the right, but instead of acknowledging doubt, bewilderment or surprise, a plausible and coherent explanation is immediately provided.[57] This suggests a curious propensity to create meaning where there is none. These subjects, however, can hardly be considered typical given intractable epilepsy was the indication for their radical neurosurgery. "Normal" subjects should fare better. Alarmingly, they do not. Shoppers in a large store were shown four identical pairs of tights and offered the chance to take home the pair they thought was of highest quality.[58] These subjects examined each of the tights in turn and most frequently opted for the pair on the furthest right by a factor of 4:1, in keeping with the well-recognised positional effect. When asked to explain their choice, subjects generated various reasons, such as the item being softer, better made, or a nicer shade but never with the true explanation, the position of their choice relative to the others. When the positional effect was suggested as a possible mechanism subjects scorned it. Thus, even "normal" subjects produce alternative explanations that are psychologically meaningful and coherent, yet erroneous. In a similar vein, Daniel Kahneman asks why highly intelligent women tend to marry men less intelligent than themselves.[59] Those foolhardy enough to volunteer an answer offer reasons that involve avoidance of competition, a preference for emotional intelligence, desiring a househusband, or some variation on the

theme. Even subjects with some statistical knowledge overlook the phenomenon of regression to the mean, which must account for a substantial proportion of the cases. Humans, Kahneman argues, are over-ready to construct psychologically meaningful explanations. Thus, the validity of meaningful explanations is thrown into doubt. Major figures in philosophy have likewise been suspicious about the cogency of meaning. WVO Quine argued that meaning is indeterminate: there are too many mutually incompatible systems of translation for each speech act to establish conclusively which is correct.[60] On the other hand, Feyereband made the claim that there is too little determinacy. As Hacking says of Feyereband's incommensurability, "Two human languages could be so disparate that no system of translation is possible."[61]

Sceptics about meaning within the experimental psychology literature argue that the speaker explains his or her own behaviour in terms fundamentally at odds with the true cause. Claims to self-knowledge are thus intriguing but ignorable, analogous with how Berrios views a patient's delusions. The philosophical sceptics are concerned that the words of one person cannot be deciphered by another with any degree of certainty. The true meaning of any assertion is forever open to dispute. If meaning is so enigmatic then the patient with psychiatric symptoms is in the same position as everyone else. Nonetheless, others have developed theories of meaning that seek to explain successful interpretation. Donald Davidson, Daniel Dennett, and Ludwig Wittgenstein have each been concerned with the philosophy of meaning. We will examine their accounts in turn after the methods chapter, but in the section that follows we consider why these three philosophers' theories in particular have been selected.

PHILOSOPHY OF MEANING AND PSYCHOPATHOLOGY

Numerous theories of meaning have been proposed over the course of the 20th century (see e.g. Hacking[62] and Ogden & Richards[63]) subsequent to Jaspers' *GP*, so it would be impossible to examine neuropsychiatric symptoms in the light of each and every one. What then is the rationale for a focus upon Davidson, Dennett, and Wittgenstein in the present study? The reasons are threefold. First, each of the three philosophies discussed is committed to the autonomy of the mental. Wittgenstein argued that meaning is normative; that is, there are

rules for the correct and incorrect usage of words and phrases. Any explanation of meaning must therefore be in normative terms rather than appealing to underlying biological or psychophysical processes. An explanation on reductive terms cannot be a genuine account of meaning for it excludes that which is most important.[64] Davidson's philosophy of mind, anomalous monism, similarly denies any simple reduction of the mental to the physical while seeking to respect the materialist basis of mind. He claimed that thought and action are constrained by the rules of rationality, which have no counterpart in the physical realm. Hence, mind is autonomous from the physical. Dennett, on the other hand, allows three levels: the physical, design, and intentional stances. Mental states such as beliefs and desires are discernable only through the intentional stance and are, we are told, real patterns demonstrable in human behaviour. While thermostats and clocks can also be spoken about *as if* they hold beliefs and desires, their "behaviour" can equally well be predicted and explained using non-intentional terms; therefore it is better to do so. True beliefs and desires cannot be so transformed, however. The autonomy of mental states is significant for it supports the approach adopted here. The search for meaning in neuropsychiatric symptoms is not amenable to biomedical investigations or even neuropsychological testing, which examines sub-personal information processing.[65]

Secondly, many, though not all, hold rationality to be a constraint upon language.[66] This view has origins in antiquity when Aristotle defined man as the rational animal. The argument runs that theoretical and practical rationality are conditions on thought and action respectively. While humans fall well short of perfect rationality they should, by-and-large, relinquish mutually inconsistent beliefs and try to satisfy their most cherished desires. Language thus presupposes rationality because only rational agents can express beliefs, preferences and intentions to act. Furthermore, interpretation of others is possible only because we all share a basic rationality, through which the coherent pattern of meanings and actions are perceptible. Distinct from Jaspers, rationality is central to interpretation and may be a more tractable quality than the rather vague "transferring oneself." Relatedly, rationality has assumed increasing importance in contemporary philosophical discussions of psychopathology generally, and aberrant beliefs in particular. Lisa Bortolotti's *Delusions and other Irrational Beliefs*[67] is a recent and especially notable example. She observes that criteria invoking rationality are replete throughout the diagnostic manuals (e.g. distorted thinking, inappropriate affect) and explicit in some definitions of mental disorder.[68]

Davidson's and Dennett's reliance on rationality as a constraint on meaning are criticised by Bortolotti in order to show that delusions are no more irrational than many other beliefs typically deemed non-pathological. Bortolotti's work is the most systematic on the relationship between psychopathology and rationality, but it is a recurring theme in the philosophical psychiatric literature, as the remainder of this thesis will demonstrate, and it merits revisiting in the closing chapter. The convergence of interest on rationality from within the philosophy of language and psychopathology suggests that philosophers connected to that tradition will have particularly valuable contributions to the current study.

The third reason for selecting Davidson, Dennett, and Wittgenstein concerns their own distinct interests in psychiatric concepts. Davidson was aware that the psychodynamics of everyday life raise the spectre of irrationality, so had to square this with the assumption of rationality central to his philosophy. While not directly concerned with psychopathological phenomena, his comments on the mechanisms of self-deception and acting discordant with one's own desires are, however, of relevance. Dennett both directly and indirectly addresses psychopathological phenomena, specifically the Capgras delusion, visual hallucinations and confabulations. He makes some quite specific claims about these phenomena and frequently invokes mental disorder as an instance where his theory of meaning fails. He is unequivocal that mental disorder equates with meaninglessness. Wittgenstein, like Davidson, reflected upon Freud, but his initial enthusiasm was curbed by society's uncritical acceptance of Freudian interpretations: "a powerful mythology."[69] Furthermore, Wittgenstein's philosophy has become highly influential in philosophical psychiatry and psychology, particularly his last writings in *On Certainty*.[70]

Davidson, Dennett, and Wittgenstein are each regarded to be exponents of analytic philosophy, broadly conceived. Of course, a separate tradition within philosophy also exists that has taken meaning as a central concern, continental phenomenology and hermeneutics. It could fairly be asked why philosophers from that tradition seem to have been sidelined but as the methods chapter explains, the methodology selected comprises of a primary hermeneutic phenomenological analysis. The relationship between the primary and secondary, theory-driven, analyses will require discussion at the end of the thesis. Phenomenologically inclined philosophers were excepted from the secondary analysis for they take meaningfulness as a founding assumption rather than something to be queried in

its own right. That the three philosophers selected have also written more or less directly on psychiatric issues enhances their appeal in addressing the main study question: does meaning falter and fail in prototypical neuropsychiatric symptoms?

SUMMARY

Meaning is, as Bolton has written, an issue that presses on many fronts in the philosophy and practice of psychiatry. It impinges upon our views on agency, comprehensibility, rationality, and the limit of disorder. Jaspers articulated the problem but his method is ambiguous on where our understanding ends. The meaningfulness of neuropsychiatric symptoms is contested, but it is suspected that they resemble neurological symptoms to a greater extent than other psychiatric phenomena. A study exploring their meaningfulness, or otherwise, through the prism of philosophical theories of meaning cannot finally settle this question; but such an exploration may serve to illuminate.

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MEANING AND METHOD

INTRODUCTION

In spite of the centrality of meaning in psychiatric theory and practice, it is surprising how sparse is the literature on its systematic evaluation, Karl Jaspers' *General Psychopathology*[1] notwithstanding. There are, however, diverse approaches to its study in psychiatric and non-psychiatric settings, which it will be helpful to review prior to setting out the rationale for and details of Interpretative Phenomenological Analysis (IPA), the approach taken here. The review covers investigations of meaning in primate behaviour and calls; psychologists' attempts to quantify meaning; evaluation of language usage in patients with schizophrenia and dementia; and experimental approaches to understanding three psychopathological symptoms: depression, confabulation, and delusion.

MONKEY GESTURES

The mark of the mental is, in Brentano's term of art, the intentional.[2] The word is derived from the metaphor *intendere arcum in*, which means literally to take aim at some object with an arrow.[3] So intentional states are aimed at something other than themselves. Meaningful acts and utterances display intentionality, as they must be about (mean) something else. (The word "cat" refers to a real or imagined thing.) Intentionality is not thought to be restricted to *homo sapiens* as this "aboutness" is seemingly apparent in primates' gestures and vocalisations also. Vervet monkeys have a specific call to notify conspecifics *about* threats and opportunities in their environment.[4] Ethologists have attempted to study systematically the intentional aspects of primate behaviour. They have developed methods to study what vocalisations and gestures are about: that is, what they mean. Therefore it seems sensible to begin our search for a method for the systematic study of meaning out in the field with the primatologists.

Cartmill and Byrne have studied primate gestures systematically. They developed a method whereby meaningful gestures are distinguished form movements devoid of intentionality. Two researchers view many hours of video footage independently and a movement is

considered potentially meaningful if both viewers judge it "motorically ineffective."[5] Additionally, the gesture must be directed towards another individual in the group; initiate a response from that individual; appear goal-directed to the researchers; and achieve the supposed goal. If a particular gesture achieved the goal attributed it by the researchers on 70% or more of occasions, then an intentional meaning is assigned that gesture. When Vervet monkeys were first observed to respond to calls made by a member of the group upon seeing a predator, it was argued that the vocalisation signified nothing more than fear and alarm. To test this deflationary theory Cheney and Seyfarth[6] embarked upon a series of ingenious experiments; they recorded different Vervet calls made in response to different predators then played these back to the group when no predator was nearby. Calls originally made when a leopard approached caused the group to scurry into the trees, while the Vervets stood bipedally to inspect the immediate vicinity on hearing the characteristic "snake" call. Such differential responses suggest at least that the calls do *mean* different things, but leaves the actual referent obscure. (Does the "leopard" call mean, "leopard," "leopard nearby," "predator," "climb the tree," "run for your lives"?) Following Grice[7] and Dennett,[8] they sought to study the complexity (order of intentionality) of the beliefs attributed. A call made in fear exhibits zero-order intentionality, it being made purely as an expression of the animal's internal state, such as a "yelp" made in pain. First-order intentionality on the other hand conveys the callers *belief* that there is a leopard nearby or that it *wants* its conspecifics to run away. Second-order intentionality requires the animal to have a belief about another's state of mind; "I *want* you to *believe* there's a leopard nearby." Fascinating and ingenious as this work is, it is not a useful methodology for the present study. In the first place, the methods are so time-consuming and elaborate because it is not possible simply to ask the Vervet what it means by "*chutter*" or "*wrr*". It is therefore inappropriate as a method to study meaning in human speech where one can just inquire about what is meant. Second, the evidence accumulated by Cheney and Seyfarth suggests that Vervets have only first-order intentionality, while Chimpanzees and Orang-utans have perhaps achieved a limited second-order intentionality.[9] Humans manage fifth-order intentionality, so the concepts they can contemplate and express are of a wholly different complexity to those expressible by primates. Let us therefore turn to the psychologists, who might reasonably be expected to have an interest in meaningful communication in humans.

WORD COUNT

Meaning has indeed been a focus for psychological research, most notably in Osgood *et al's The Measurement of Meaning*.[10] However, the aspect of meaning that appears to capture the imagination of such writers is the quantification of meaning and relating the meaning of one word to semantically related ones. Thus, most of the studies examine meaning through quantifying the strength of associations; the similarity of semantically related words; the extent to which one can be substituted for another; and the classification of words into groups based on likeness.[11] This method can be contrasted with Osgood's Semantic Differential. Here subjects are asked to rate what particular words connote on various scales that aggregate around three factors: evaluation (good vs. bad), potency (strong vs. weak), and activity (active vs. passive.) Every word occupies a position in the matrix, which indicates the word's connotative meaning. Such an approach has been applied to the psychopathology of depression, finding that the depressed rated both self-referential and external concepts as less positive, less potent and more passive than non-depressed controls.[12] However, meaning here is conceived in purely quantitative terms and is far removed from the qualitative un-understanding described by Jaspers.

SYNTACTIC STRUCTURES

Cutting, in a study exploring the semantic comprehension of patients with schizophrenia, a manic episode of bipolar affective disorder, and depression, found that those with schizophrenia more readily report literal than metaphoric meanings of words.[13] This though relates to comprehension rather than the production of meaning, so is not a viable method here. Researchers interested in language production have discovered a number of abnormal features in those with schizophrenia. In a review of the research to date, Kuperberg describes how healthy controls struggle to predict words omitted from patients' transcripts; patients use weaker but more numerous associations than controls; and sentences are constructed according to the meaning of prior words rather than around a particular topic or theme.[14] Similar investigation of semantic and syntactic properties of speech have been employed in Alzheimer's disease, most notably in Peter Garrard's studies of Iris Murdoch and the late Prime Minister, Harold Wilson. Such work has origins in Snowdon *et al's*[15] famous Nun study, which demonstrated that the quality – measured in terms of idea density and grammatical complexity – of Nuns' brief autobiographies written in their early 20s was

predictive of dementia in late life. Low idea density (defined as the average number of ideas expressed per ten words) is associated with a greater chance of Alzheimer's disease in later life. Garrard *et al*[16] examined three novels produced by Iris Murdoch at different stages in her life. These showed that her lexicon shrank and there was increased repetition in her last book, suggesting syntax is relatively preserved in the preclinical period of Alzheimer's disease even as semantics deteriorate. Again, these methods of textual analysis are ill suited to the investigation of meaning given their focus on the quantitative properties of language. Furthermore, it is acknowledged that while sentence complexity is inversely correlated with severity of dementia, the output retains coherence,[17] i.e. understandable to an audience.

MELANCHOLY MEANINGS

In *Social Origins of Depression: A Study of Psychiatric Disorder in Women*, Brown and Harris oppose Beck's stipulation that psychopathology must be a consequence of "perseverative faulty conceptualisations"[18] of external events. Instead, they argue it is the nature and meaning of severe life events that causes depression without anything being faulty *within* the individual. As they wished to avoid the circularity of classifying an event according to the reaction it caused, they developed a method to measure the meaning of events. An interviewer informally asked numerous questions covering the period around each life-event, exploring feelings and attitudes, to gain a sense of the event's significance for the subject. Interviews were tape-recorded and the index events scored on twenty-eight rating scales measuring characteristics such as expectedness, availability of support, etc., including the subject's self-report of the event's meaning. The material was used to, "make a judgement about the likely meaning of the event for the average person in such circumstances without considering her personal reaction."[19] This seminal work developed novel techniques to explore meaning and its relation to psychopathology. But it was the meaning of events not utterances that was investigated plus "the average person" is an inappropriate statistical concept where the question is whether something can or cannot be understood.

CONFABULATED MEANING

Brown and Harris' method was similar to that employed by the contemporary experimental neuropsychologist Aikaterini Fotopoulou,[20, 21] who attempts to provide an account of confabulatory content. She argues that what appears meaningless does in fact betray hidden motivations – to protect self-identity and coherence, for instance – and meanings. Interestingly though, repeated incoherent or obscure confabulations were excluded from the study. To investigate her hypothesis she devised a method to establish whether the emotional valence of confabulations is positive, negative or neutral. The confabulations were presented to a panel of blinded researchers along with details of the original event suspected to be the confabulation's source. The panel then individually decided whether the confabulation was more or less positive than the original event. The method demonstrates the value of lengthy open-ended interviews but a blinded panel could not usefully comment on whether a mental state is meaningful or not. How would disagreements be resolved? That some mental states in the severely mentally ill are meaningless is a widely held intuition. It is the basis of this intuition that is at question in the present study.

METAPHORICAL MEANING

Given Richard Gipps and John Rhodes have recently argued that delusions constitute a breakdown of the Wittgensteinian "bedrock,"[22, 23] it is significant that Rhodes has, with Simon Jakes, investigated qualitatively the content of patients' delusions. Their original paper examines whether the content directly corresponds with current or long-standing problems encountered by the patient in his or her everyday life[24] while a subsequent study explores whether the delusion can be taken as a metaphor for psychosocial adversity.[25] The results appear to confirm their hypothesis (and professional presuppositions) that the content of delusions is indeed meaningful if only one looks hard enough. However, this conclusion may be too strong as only eleven of the 25 patients interviewed for the latter paper expressed content that could be understood as metaphorical in some way. Clearly, therefore, the content of delusions cannot be accounted for through metaphor alone. Nevertheless, the Interpretative Phenomenological Analysis (IPA) methodology employed is intriguing and clearly relevant to the present study. The method is valuable for it aims to gather rich and detailed first-person experiential data. This could be useful when talking to carers about their experiences when trying to understand their loved-one's altered mental

state. It also allows investigations of patients' experiences making sense of themselves and their neuropsychiatric phenomena. This first level of analysis aims to be as theory-neutral as possible. IPA however facilitates a further level of analysis; the rich interview data enables secondary analyses grounded in a chosen theory or theories. This method seems exactly right therefore. The first theory-neutral level of analysis will derive themes related to patients' and carers' attempts to understand the unusual neuropsychiatric symptoms, while secondary theory-driven analyses can be grounded in our three philosophers' respective theories of meaning. This appears the right direction in our quest for mutual illumination.

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

THEORETICAL BACKGROUND: PHENOMENOLOGY

Jonathan Smith developed IPA as a qualitative research method for health psychology.[26] The field, he said, had become too concerned with quantification eschewing legitimate areas of study resistant to simple measurement. The particular significance and meaning of an illness for the individual concerned could not be quantified hence its being systematically ignored. Smith, therefore, sought a method to restore meaning within psychology. Echoing Jaspers in *General Psychopathology*,[27] methods from both the Natural and the Human sciences must be employed where Man is the object of study. IPA is rooted in the turn-of-the-20th-Century German philosophy that sought to re-engage in lived experience rather than the abstract theorising into which it had fallen.[28] Indeed, both phenomenology and hermeneutics invigorated philosophy with their claims to priority over the realm of science. Phenomenology studied only that which is accessible in consciousness, and hermeneutics became the "science" of interpretation. Smith *et al* cite a number of figures within these traditions as influences for the theoretical underpinning of the method[29] (though it could be argued that discontinuities and differences between these figures are minimised or glossed.) Edmund Husserl is credited with beginning this reorientation of philosophy and for developing the phenomenological method by which the fundamental components of conscious experience could be examined. In order to intuit the essence of an experience, all assumptions, theorising, and knowledge (both commonsensical and scientific) must be "bracketed" or, in other words, kept out. Thus, different practitioners should each discover the same essence of an experience, so a singular experience yields a universal truth. From

Husserl, IPA takes the concern for individual experience and the process of bracketing off presuppositions, though this is now acknowledged to be only partially possible, as we will see below. Also, Smith argues, Husserl provided an inadequate account of intersubjectivity and that it is not at all clear from his solipsistic phenomenology how one mind can comprehend another, which is key to the IPA project.

THEORETICAL BACKGROUND: HERMENEUTICS

To remedy these perceived deficiencies, Smith *et al* appropriated Heidegger's so-called hermeneutic phenomenology, in which the emphasis in phenomenology shifted to the experience of being engaged in the world and with each other. In *Being and Time*,[30] Heidegger painstakingly described (in jargon of his own creation) the structure of this engagement. When one perceives a hammer, one sees it *as* a hammer, which can be used *for* its particular purpose. There is no raw sensory data out there that is then computationally analysed to generate a mental representation, "HAMMER." Other minds cease to be a puzzle in Heidegger's phenomenology because the distinction between a mind "inside" and the world "out there" dissolved. His phenomenology was hermeneutical as a fundamental aspect of our *Dasein* (Heidegger's term for human existence) is that we ceaselessly interpret the world and others around us. As with the hammer, we just cannot see and hear things apart from their interpretation. One always hears a noise as the sound of something. Interpretation, and hence meaning, is foundational. We are each of us enmeshed in a sphere of meaning, within which language operates. So, *contra* Husserl, bracketing cannot remove all presuppositions. For Heidegger, interpretation is circular and never complete. One takes one's presuppositions to interpretation, and these presuppositions are amended in the light of what one discovers. *Angst* is a rare moment where this network of meaning, this automatic engagement with the world, is shaken. One feels adrift and life feels meaningless. This leads directly to Sartre's "existence comes before essence," which stresses that finding coherent meaning in one's activities and relationships is a continuous process that becomes even more vital during times of heightened significance, such as threat and sickness; exactly where IPA is recommended. Hans-George Gadamer is another philosopher in the phenomenological hermeneutic tradition to whom Smith *el al* refer. For Heidegger, interpretation was not a skill or technique specific to any theoretical school but instead a prerequisite of all human existence. However, for Gadamer there was greater emphasis on interpreting each other through the medium of language and

a commitment to dialogue.[31] Listening and attending to one another brings greater depth of interpretation and there is the potential for both to walk away in mutual understanding. Language is coloured by the traditions and culture in which it resides, so all interpretation brings assumptions and prejudice, which must be acknowledged in the interpretation, and these assumptions and prejudices should be open to amendment in the light of the phenomenon or dialogue. This is the hermeneutic circle, where interpretation is endless. The search for common agreement was criticised by Habermas for conceding too much to tradition, and by Foucault as concealing a will to dominate. This is, as Smith *et al* acknowledge, a tension within Gadamer's work. Paul Ricoeur in his *Freud & Philosophy*[32] distinguished between a hermeneutics of trust and a hermeneutics of suspicion. The former seeks to restore original meaning and understand the other as they themselves do. Those schools that practice the latter, such as psychoanalysis and Marxist theory, however, are united in their "decision to look upon the whole of consciousness as 'false' consciousness."[33] They offer interpretations couched in their own conceptual terms that he or she so interpreted could not accept without the necessary theoretical revelation (or indoctrination.) An interpretation developed in a hermeneutics of suspicion may be rejected, such as the analysand who resists interpretation in terms of the Oedipal complex. IPA aims for a central course between these two polarities of interpretation: "We are attempting to understand, both in the sense of 'trying to see what it is like for someone' and in the sense of 'analysing, illuminating, and making sense of something.'"[34] This is achieved through the completion of deepening levels of interpretation, discussed below.

To summarise, IPA recalls a rich if abstruse seam of philosophy dating to the early 20th Century and before. But it is the concern for our everyday experiences, interpretation as a cyclical back-and-forth and the focus on the particular that distinguishes IPA from other qualitative methods and situates it in stark contrast to quantitative research.

CASES AND INTERVIEWS

IPA has specific demands regarding selection of cases. It is recommended they be selected purposively as opposed to random sampling, the staple of quantitative research. Cases are selected for their particular perspective on the phenomena of interest. In the present study the meaningfulness of neuropsychiatric symptoms is of primary interest; hence each case

presented a clear instance of psychopathology in neurological disorder. Furthermore, the symptom had to be assessable through language alone. Three cases were recruited. One presented with confabulation, another with visual hallucinations, and the last suffered with Capgras' delusion.

Both first-person and third-person perspectives on the meaningfulness of symptoms were sought, so a carer was recruited for each case. Unfortunately, this was not possible for Liz (Case 2) who suffered visual hallucinations. Given the importance of language in eliciting these symptoms and conducting an IPA interview, all participants were required to speak English as their first language. None of the patient participants had a significant degree of cognitive impairment (considered as scoring 69 or less on Addenbrooke's Cognitive Examination-III), or a comorbid primary psychiatric disorder, such as depression or schizophrenia. Participants were recruited through the Department of Psychological Medicine at the Royal London Hospital where the author works as a consultant psychiatrist and via Professor Michael Kopelman's neuropsychiatric out-patients' clinic at St Thomas' Hospital. Those recruited via the author's clinical work had their clinical management handed to a consultant colleague in the team to avoid potential conflicts of interest. Professor Kopelman briefly informed his cases about the nature of the research before forwarding their contact details. All participants received an explanation of the study and were provided with a written information leaflet for their consideration. Each participant signed a consent form (see Appendix A & B for examples of the information leaflet and consent form, respectively.)

The methodology demands the interview follow the concerns and interests of participants; encourage them to tell their own story; speak freely; and to reflect upon their experiences. It is, "a conversation with a purpose."[35] Semi-structured questionnaires are preferred because they facilitate and guide the conversation but are not overly prescriptive, so can follow the participant as s/he roves around a topic. Accordingly, the author developed a semi-structured questionnaire with the purpose of gaining a detailed description of the participants' experience of making sense of neuropsychiatric phenomena. Smith recommends beginning with an open question that requires description of a particular event, with subsequent questions inviting progressively more self-reflection and analysis. The study question cannot of course be asked directly, so interview questions were

suggested through consideration of the philosophers' theories of meaning. Draft questionnaires for each the patients and carers were prepared, discussed with supervisors and modified in light of these discussions. The final draft version of each questionnaire was then used in a pilot interview with either a patient or carer. The pilot interviews revealed some ill-posed questions that were difficult for participants to understand. For instance, the pilot questionnaire asked of carers: "How do you understand what s/he meant by… ?" The question is overly ambiguous as the "how" can either refer to a practical process of know-how, or *in what way* something was intended by the other person. As the question aimed after the former, it was reformulated in subsequent versions to: "Do you have a way of understanding what is said?" The subsequently modified questionnaires were again discussed with supervisors and final versions agreed (see Appendix C & D for patient and carer semi-structured questionnaires, respectively.)

The interviews were completed either in the author's clinical rooms at the Royal London Hospital or the research interview room in Professor Kopelman's department at St Thomas' Hospital. Both rooms are quiet, warm, clean, and reasonably comfortable. Interviews lasted one hour and involved the participants being asked about their understanding of the neuropsychiatric phenomena experienced by himself or herself or the person for whom they care. The interviews were recorded on a digital recorder, stored on the author's password secured computer, and then transcribed for analysis. Given the intensive and onerous nature of IPA analysis the aim is high quality information from a small number of participants. Therefore, Smith *et al*[29] recommend that studies for professional doctorates should complete between four and ten interviews. Given that secondary analysis was to comprise a far greater element of this study than is usual for IPA, it has been necessary to keep to the lower end of this range. Five interviews were completed and their primary and secondary analyses are presented in *Results: Part A* and *Part B* respectively.

Ethical approval for the study was gained through the National Research Ethics Service (REC) Committee London – Queen Square and approved on 13th January 2013 (see Appendix E for approval letter for study 13/LO/1735, *Meaning and Meaninglessness in Neuropsychiatry: Understanding Psychological Symptoms*.) Approval for recruitment at each NHS site was granted by the relevant local Research & Development Departments at Guy's and St

Thomas' NHS Foundation Trust, Bart's Health – QMUL Joint Research Office, and South London and the Maudsley NHS Foundation Trust.

ANALYSIS

The purpose of the analysis in IPA is to move from a clear understanding of the participant's personal perspective to an interpretation of those experiences at a more theoretical and conceptual level: from a hermeneutics of trust towards one of suspicion. However, as opposed to Marxism or Freudian psychoanalysis, the interpretations made in IPA are grounded in, though go beyond, the personal perspective. Interpretations typically connect with theoretical perspectives such as cognitive psychology and phenomenology but there is no limit to the integration of IPA with other theoretical positions. This is part of its appeal to the current study. Smith *et al*[29] recommend that secondary analyses be clearly demarcated from the standard IPA analysis to avoid confusion and to emphasise the more speculative nature of the former. The analysis moves through a series of phases, though these are intended as rough guides rather than formal axioms or instructions. IPA analysis needs time, reflection, imagination and creativity rather than the rigid application of operationalised rules. The stages are described in Smith *et al's* 2009 textbook.[29]

STEP 1

The transcript is read and re-read alongside the audio recording to develop familiarity with the structure, pace and tone of the interview. Later, the participant's voice is imagined rather than listened to. At this stage, the analyst notes any powerful recollections or impressions in order that these can be placed to the side for a time ("bracketed off," in Husserlian terms) to ensure one captures the participant's perspective and sense.

STEP 2

Initial notes on the semantic content and use of language are made directly onto the transcription. This is an exploratory phase unbounded by rules of what should or should not be noted. However, this time-consuming and laborious task generates extensive notes that engage with the participant's actual words. Comment types fall into three overlapping

categories: descriptive, linguistic and conceptual. Descriptive comments make note of key objects, experiences and events in the participant's discourse. These are often highlighted by the use of descriptive language, sound bites, acronyms, idiosyncratic figures of speech, and emotional responses. These descriptive notes take what is said at face value, but as the analysis deepens, richer accounts of the meaning of these events and experiences develop. Linguistic comments relate to the use of pronouns, tense, repetition, laughter, pauses, tone, fluency of speech, etc. Note is also made here of metaphor. Conceptual comments mark a shift from specific answers and instances towards a more overarching understanding of the interview. Conceptual noting begins to draw on the analyst's own experiential and professional knowledge. The aim is to begin to open up a range of provisional meanings. All interpretations are considered legitimate so long as they remain tied to and grounded in the actual text: "What is important is that the interpretation was inspired by, and arose from, attending to the participant's words, rather than being imported from outside."[36]

STEP 3

This phase of the analysis moves to dealing with the notes made rather than the primary text. Emergent themes that speak to the psychological essence of the comments are captured in pithy phrases that reflect not only the participant's original words but also the analyst's interpretations. The emergent themes reflect discrete portions of the text but should also make sense of the interview as a whole.

STEP 4

In this phase the emergent themes are reviewed for possible connections. There are a number of ways in which emergent themes can be connected, so this process is not dogmatic but rather creative and participatory. For example, one could connect themes by abstraction – placing a number of conceptually linked themes under one superordinate category. Similarly, one emergent theme could become a superordinate category itself, if it organises other emergent themes. Polarisation involves an opposition between emergent themes (e.g. wanting to live while wanting to die.) Contextualisation organises themes in relation to the temporal context in which they emerge, while function organises themes in terms of the role played in the discourse. The frequency with which emergent themes arise can be recorded numerically. However, caution is required here, as frequency need not

correlate with import. The results from this phase of primary analysis are presented in *Results: Part A.*

STEP 5

Once the above has been completed for one case, the analyst can move on to the next interview. Themes developed during the earlier analysis should be set aside as each interview should be analysed on its own terms and the themes should arise principally from the text. As the current study involves bringing in a range of theoretical concepts derived from philosophical theories of meaning these analyses will be presented in *Results: Part B*. First, in the following chapters, the three philosophers' theories of meaning require explication and comparison.

SUMMARY

As stated in the *Introduction*, there is no clear precedent for investigating whether meaning falters of fails in psychiatric and neuropsychiatric phenomena. While meaning presses on several fronts, the methods reviewed above demonstrate that no particular methodology can obviously assist the present study. Nevertheless, IPA is attractive for it enables one to gather rich information about the participants' lived-experiences while also allowing a theory-driven secondary analysis. Given the aim is for mutual illumination of the theories of meaning alongside an exploration of participants' experience of meaning making, IPA seems an apposite approach, although success cannot be assured. The qualitative study of meaningfulness in psychiatry is without precedence, almost. The chosen method, however, bears similarity to Jonathan Glover's study of the alleged amorality of psychopaths.[37] Eschewing a formal methodology like IPA, Glover instead brought his experience of elucidating students' moral reasoning through Socratic questions to the semi-structured interviews he conducted with Broadmoor patients. Like IPA however, he aimed for a conversation that followed leads and hunches in order to draw "the contours of a moral landscape" and generate themes for further reflection. Glover found the psychopaths to be morally shallow, self-interested, and preoccupied with fairness and personal rights: "It is a *moral* landscape, but a narrow and hard one."[38] Nevertheless, he felt able to situate the landscape within both moral philosophy and the inmates' traumatic lives. Glover's technique

resembles the secondary theory-driven level of analysis in IPA. Similarly, the present study will place greater emphasis upon the secondary analysis than is standard for IPA because the primary analysis in IPA assumes the very thing that is here in question: are neuropsychiatric phenomena meaningful? So the non-standard approach is legitimate. The following three chapters develop the philosophical conceptions of meaning to be utilised in the theory-driven secondary analyses. Each philosophy of meaning will generate specific, at times overlapping, claims that can be interrogated against the data derived from participants' interviews. A brief chapter outlining the philosophical aspects to be tested against the interviews concludes the philosophical explications.

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DENNETT'S INTENTIONAL STANCE

INTRODUCTION

Daniel Dennett, dubbed one of the horsemen of atheism following a sceptics' panel discussion called *The Four Horsemen*, disparages the shielding of fundamental problems behind a "veil of mystery."[1] This atheism coheres with his primary philosophical concerns: the naturalization of mental content, free will, and consciousness. With regards mental content, Dennett proposed a highly influential theory that sought to account for the success of our third-person predictions of complex systems, such as chess-playing computers and human beings. His theory of content, called intentional stance theory,[†] has been highly influential since it is compatible with two contemporary scientific programmes: evolution and artificial intelligence (AI). He demystified content by grounding it in evolution, giving succour to the AI project of creating machines that comprehend and act. He first articulated his theory of content in *Intentional Systems*[2] but subsequently called *True Believers*[3] the "flagship expression"[4] of his position.

The frequency with which Dennett makes reference to mental disorder as a boundary case for his theory is intriguing. Mental disorder is an instance where neither interpretation nor prediction of the person afflicted is possible from the intentional stance.

> In extreme cases personalities may prove to be so unpredictable from the intentional stance that we abandon it, and if we have accumulated a lot of evidence in the meanwhile about the nature of response patterns in the individual we may find that a species of design stance can be effectively adopted. This is the fundamentally different attitude we occasionally adopt towards the insane.[5]

[†] This is Dennett's own term. It could easily be swapped for strategy, perspective, or view. Stance does, however, convey the element of volition. Observers choose the intentional stance for the prediction of complex systems and can opt to switch to another stance at any time.

> The performing of actions is the restricted privilege of rational beings, persons, conscious agents, and one establishes that something is an action not by examining its causal ancestry but by seeing whether certain sorts of talk about reasons for action are appropriate in the context. On this basis we exculpate the insane, with whom one is unable to reason, unable to communicate.[6]

> In cases of even the mildest and most familiar cognitive pathology – where people seem to hold *contra*dictory beliefs, or to be deceiving themselves for instance – the canons of interpretation of the intentional strategy fail to yield clear, stable verdicts about which beliefs and desires to attribute to a person.[7]

The severity of mental disorder specified by Dennett as necessary to undermine interpretation seems to have varied from mild cognitive pathology through to "insanity" (undefined) and brain damage. Nevertheless, it is clear that he considers mental disorder a paradigmatic instance of when the intentional stance, viewing the sufferer's utterances as meaningful and rational, should be abandoned. Indeed by Dennett's reasoning, this undermines the very legitimacy of granting such individuals full personhood.[8] He has also criticised psychoanalytic understanding of psychiatric symptoms as a "gratuitous and incautious"[9] overextension of the meaningful into the biological realm. Thus, for Dennett, much of the content expressed in psychiatric symptoms is uninterpretable from the intentional stance. This is, however, an inference that is never put to the test.

This chapter provides an overview of Dennett's theory of content with particular reference to the underlying assumptions one must adopt when using the theory for third-person perspective interpretation and prediction of another agent. Specifically, the assumptions that he will believe and desire what he ought and is also optimally rational. Next, we will examine two connected aspects of Dennett's theory that bear on the question of interest here. These aspects are i) the status of belief within the intentional stance theory and ii) the indeterminacy of meaning. Dennett holds a complex and contested view on the ontological status of belief that has certain implications for psychopathology, and his indeterminacy seems to allow multiple valid interpretations of the same objective behaviours. The chapter concludes with a discussion on the utilisation of Dennett's intentional stance in the experimental clinical setting.

DENNETT'S INTENTIONAL STANCE

The intentional stance should first be contrasted with two other "stances" that can be adopted when predicting future events: the physical stance, and the design stance. Only then can the distinctive intentional stance be understood. In the physical stance prediction is based on the application of knowledge of causal processes at the physical and microphysical level. Thus, the location and speed of a comet can be calculated for any time in the past or future according to Kepler's Laws. Dennett explicitly disregarded the indeterminacy of subatomic particles. Rather, it is predictability from the physical stance in principle that should be accepted. There are occasions when the adoption of the physical stance necessitates over-lengthy and time-consuming calculations. Where a system has been designed to perform a particular function it is quicker and easier to adopt the design stance to predict future behaviour. Basically, one predicts behaviour based upon knowledge of the design and the – somewhat risky – assumption that it is operating as designed. It is important to note only designed behaviours can be predicted from the design stance.

To take the clock as an example, it is possible to predict the state of any clock 59 minutes hence from either the physical stance or the design stance. To adopt the physical stance may require complex maths involving spring torsion, oscillators, impulse actions and suchlike in the case of a mechanical clock or completely different calculations and laws for a digital one. The design stance, on the other hand, allows simple and accurate prediction of its future state whatever the clock's inner-workings, provided it is functioning as designed. Should the clock be malfunctioning or poorly designed the design stance is no help in predicting behaviour. To do so, one must drop to the physical stance. The design stance is really a range of stances from the concrete through to the abstract. For example, a computer can be predicted in terms of the source code (abstract level) down to the flip-flop switches (concrete level) that instantiate it.

In the case of highly complex structures, such animals and humans, the underlying design remains unknown yet still we are able to predict future behaviour. One easily predicts the outcome when a cat spots a mouse. Prediction is successful because it is natural for us to adopt the so-called intentional stance towards other complex objects and organisms.

> Here is how it works: first you decide to treat the object whose behaviour is to be predicted as a rational agent; then you figure out what beliefs the agent ought to have, given its place in the world and its purpose. Then you figure out what desires it ought to have, on the same considerations, and finally you predict that this rational agent will act to further its goals in the light of its beliefs. A little practical reasoning from the chosen set of beliefs and desires will in many – but not all – instances yield a decision about what the agent ought to do; that is what you predict the agent *will* do.[10]

Thus, one assumes that the cat ought both to believe there is a mouse nearby and to desire eating it. Therefore, one predicts the cat will stalk its prey. The intentional stance is, Dennett has more recently conceded,[11] a variety of the design stance but a highly abstract and risky stance to adopt; risky because of the additional assumptions involved.

THREE ASSUMPTIONS

The first assumption is that an agent does indeed have the beliefs it *ought*. For Dennett, humans and animals come to believe mostly true and relevant facts about the world they inhabit. Some beliefs are false, but these require a special story to be told that involves predominately true beliefs. Likewise, we hold certain sophisticated beliefs unrelated to direct experience – for example, the belief that all matter is composed of waves – that may be true or false or neither. However, these beliefs are grounded in true beliefs related to direct experience of the environment, and such beliefs are a minority of all the beliefs we hold (if beliefs could be individuated and counted, although Dennett has assured us they cannot.[12]) A related assumption is that the agent desires what it *ought*; the most basic of which include survival, food, procreation, pleasure, comfort, and absence of pain. Belief and desire are interdependent upon each other and come to be known through consideration of the agent's ecological niche. The opportunities and threats in the environment enable the identification and weighting of goals relative to that agent's needs for survival, safety, and nutrition. Its beliefs and desires will be evident in behaviour, as beliefs about the environment guide the agent towards the fulfilment of desires. Likewise for false-beliefs, destructive or misevaluated desires require a special story to be told that shows they derive, in the main, from salutary ones. What permits the assumption an agent has the beliefs and desires it *ought*? Natural selection over prolonged periods ensures that it is optimally

adapted to its environment, for it is precisely those design features that increase the probability of propagation and survival that are selected. Thus, the organism must believe most of what it ought about its environment to maximise its survival prospects and most, if not all, those beliefs will be true. Its desires will also be commensurate with the capacity to thrive in that niche. Dennett is strongly committed to the view that evolution produces optimal design[13] and that biological design can only be apprehended in light of it.[14] The third and final assumption – intentional systems are rational – is perhaps the most contentious[15, 16, 17,18] and is closely tied with this assumption of evolutionary optimality. Beliefs and desires can be inferred from behaviour only because the behaviour is rational in terms of those beliefs and desires. If someone wants a glass of milk and believes there to be milk in the fridge, his looking under the bed for milk would appear irrational. Indeed, the belief "milk is in the fridge" is difficult to ascribe based upon that behaviour. However, Dennett has stated that intentional systems, including humans, are less than perfectly rational; the intentional stance requires merely that we assume a myth of rationality in order to ascribe beliefs and desires.[19] But a consequence of the optimal design bestowed by natural selection is that organisms approximate ideal rationality well enough for that assumption to pay off, in most instances. Evolution certainly produces shortcuts and cheats that would fail to satisfy the canons of ideal rationality, but these are not so severe as to undermine the myth. If a systematic weakness in our reasoning were to be discovered, Dennett suspects it will be there for good (evolutionary) reason and "its elimination would be more costly than we might have imagined."[20] For example, never again eating chicken because its consumption once preceded sickness can be viewed as rational because the risk of recurrence outweighs the cost of over-generalisation.

Dennett has been reluctant to specify in advance what constitutes rationality without conceding that this undermines his project. Rationality is pre-theoretical, a general term of approval; it consists of shared understandings of what makes sense, which are, to some degree, innate.

> What else, in the end, could one rely on? When considering what we ought to do, our reflections lead us eventually to a consideration of what we in fact do; this is inescapable, for a catalogue of our considered intuitive judgments on what we ought to do is both a

> compendium of what we do think, and a shining example (by our lights – what else?) of how we ought to think.[21]

We are, in other words, the gold standard by which to judge the rationality of other intentional systems, including other people. This is not swallowing whole a mass of rules but a generative capacity, like language, that enables us to interpret events – quotidian and novel alike. Formal systems of rationality, such as decision theory, game theory, and the rules of inductive and deductive logic, are not followed slavishly but, like a dictionary, can usefully be consulted when considering what is rational in the circumstances. Dennett even condones those, such as Cohen,[22] who argue that the ultimate judge of the rational is intuition. This really does place the interpreter as the final arbiter of rationality.

DENNETT'S BELIEF

In *Intentional Systems* Dennett claimed that the intentional stance was merely an optional and pragmatic perspective which delivers the same predictions as the design stance but with greater economy. Adopting the intentional stance was a decision for the interpreter. This had a significant bearing on the ontological status of beliefs and desires:

> For the definition of Intentional systems I have given does not say that Intentional systems *really* have beliefs and desires, but that one can explain and predict their behaviour by *ascribing* beliefs and desires to them.[23]

So, one moment we adopt the intentional stance to the protozoon and attribute beliefs, next moment the design stance is adopted and the beliefs disappear. Beliefs are instrumentalistic. In this view beliefs "are not candidates for truth or reference, and the theories have no ontological import."[24] In subsequent iterations Dennett has refined his position. Most significantly, the intentional stance remains optional "but the facts about the success or failure of the stance, were one to adopt it, are perfectly objective."[25] Dennett resists outright realism about beliefs as this would entail each and every belief having an analogue somewhere "in the head," in turn implying a neural Language of Thought (LoT), *à*

la Fodor.[26] Although initially a supporter of LoT, once "the only game in town,"[27] he has never held that realism about beliefs necessitates a LoT. Connectionism offered up another game, one that dispenses with LoT, and Dennett has been learning to play it ever since.[28] So what is belief if neither a useful fiction nor something "in the head"? Belief is a "real pattern"[29] that can only be discerned from the perspective of the intentional stance. These patterns are there to be seen but remain invisible until one adopts the intentional stance; they are visible to us because we are designed (by evolution and culture) to detect them.[30] The pattern is not visual but intellectual and it reflects a behavioural disposition of the brain/body.

> [*W*]hat *it means* to say that someone believes that *p*, is that that person is disposed to behave in certain ways under certain conditions.[31]

So beliefs (and desires) are neither fully in the eye of the beholder nor discrete objects in the brain of the believer. Rather, beliefs are a product of interaction: a pattern produced by one, interpreted by the other. Intentional states take on an appearance of definiteness – beliefs can be highly detailed and elaborated – as a consequence of the precision of language. This appearance is, however, a distortion that drives the intuition there must be an almost infinite number of individuated beliefs inside the brain. For Dennett, beliefs are vaguer and more tacit than we generally suppose.[32] While the intentional stance can be usefully brought to bear on many systems in terms of prediction, not all intentional systems are fully-fledged believers. Dennett has claimed these lower status intentional systems hold metaphorical "as if" beliefs not real ones, but that these degraded beliefs are on a continuum. No "bright line"[33] differentiates them from the "real" beliefs held by humans. Dennett offers a so-called black-box vision of psychology in which an understanding of brain processes is unnecessary. He has also described a more scientific "sub-personal cognitive psychology" that focuses on the details of how information is processed in the brain. The intentional stance can be usefully adopted towards these sub-personal processes, but the ascribed beliefs and desires are the "as if" variety: only whole systems can possess genuine beliefs and desires.[34] There is no straightforward reduction of one theory to the other, however. Folk psychology, how we go around interpreting each other and ascribing meaning, is autonomous and independent of its realisation in the brain.

INTERPRETATIVE INDETERMINACY

The intentional stance is a deliberate decision to assume a certain standpoint from which real patterns can be perceived. However, multiple interpretations of the pattern may be possible. How then to adjudicate between them? In *The Interpretation of Texts, People, and Other Artefacts* Dennett notes that this problem has also vexed critical theorists. The traditional answer, "ask the author," has been demolished by the intentional fallacy: "it is simply a mistake to suppose that the author's personal opinion about the meaning of a text is *authoritative*."[35] The intentional stance is avowedly third-person and objective[36] so the agent to be interpreted is not granted privileged access to his or her own beliefs and desires. Everyone must continually generate hypotheses through which to interpret their own behaviour just as they do when interpreting others. Dennett has called the results of such self-reflection "approximating confabulations."[37] Approximating because language forces an artificial definitiveness on self-reported beliefs and desires. A self-interpreting agent may succeed in convincing itself of these clear-cut beliefs and desires governing its actions. When quizzed, one may report the wish for a 30-day-hung rib-eye steak when really all that is desired is sustenance. Thus, personal avowals of belief and desires are interesting and available but need not restrict the interpreter.

There can be no appeal to any underlying fact of the matter about true meaning, merely alternative interpretations. What makes some interpretations better than others is determined by the degree to which they accord with rationality. It will be recalled that for Dennett we are by-and-large rational because close-to-optimal solutions are naturally selected. Meaning is thus grounded in evolution. The assumption of rationality serves to massively reduce the number of potential interpretations, and as the volume of data to be interpreted increases, there is a corresponding diminution of distinctive patterns. But:

> I also maintain that when these patterns fall short of perfection, as they always must, there will be uninterpretable gaps; it is always possible in principle for rival intentional stance interpretations of those patterns to tie for first place, so that no further fact could settle what the intentional system in question really believed.[38]

To illustrate this point, *Real Patterns*[39] includes a discussion of two psychoanalysts who offer rival interpretations of the same patient. There is a fair degree of overlap but also points of significant difference. Only one correctly predicts the patient's suicide. For Dennett this success does not necessarily indicate a superior interpretation. So, intriguingly, the intentional stance can generate different sets of beliefs and desires for the same system, each of which is valid and "real."

IN THE CLINIC

Essentially, the intentional stance is a theory about how one is able to make sense of and predict the other, "tacitly and unconsciously."[40] However, when confronted by puzzling or peculiar behaviour, the strategy becomes effortful and explicit; the act of interpreting enters awareness. Neuropsychiatric phenomena are paradigmatic instances where additional effort is required to adopt the intentional stance. In light of the explication given above, various themes emerge for exploration within the context of the interviews. In what follows, these themes are emphasised by italics.

Firstly, how does the interpreter determine the beliefs someone ought to hold? How, from a third-person perspective, can the interpreter establish whether the other holds the beliefs he ought?

> A system's beliefs are those it *ought to have*, given its perceptual capacities, its epistemic needs, and its biography. Thus, in general, its beliefs are both true and relevant to its life.[41]

Likewise, in the "radical translation" of interpreting vervet monkey behaviour and vocalisations the interpreter must obtain:

> [A] tentative catalogue of their needs – their immediate biological needs as well as their derivative, *informational* needs – what they *need to know* about the world they live in.

When interpreting fellow humans the matter of producing a "tentative catalogue" is somewhat easier given perceptual abilities and epistemic needs are shared. Therefore, *the interpreter's default is to attribute her own beliefs about the immediate environment to the other agent*. Portions of a belief system are not concerned with beliefs about the environment and our place within it but are non-perceptual beliefs derived from culture, education, life history, and psychosocial development. *Determining whether someone holds the non-perceptual beliefs he ought requires knowledge of his personal history and culture.* Intentional stance interpretation is possible in the case of non-linguistic systems, but being able to actually talk "with the natives" allows rapid testing of differing interpretations. However, self-reports are interesting but not privileged: *it is for the interpreter to decide on the credence given to self-reported beliefs*.

Dennett's conception of rationality is normative, in that it sets a standard for rationality against which we can be judged. A certain, although unspecified, degree of slack is permitted beyond which we encounter irrationality, whereupon the very possibility of ascribing intentional states falters. *An interpreter, however, will do her best to preserve the assumption of rationality, preferring to modify the beliefs ascribed*.

> The presumption of rationality is so strongly entrenched in our inference habits that when our predictions prove false, we at first cast about for adjustments in the information possession conditions (he must not have heard, he must not know English, he must not have seen X,…) or goal weightings before questioning the rationality of the systems as a whole.[42]

For Dennett, the gold standard comparator of another's rationality is one's own. Hence, *irrationality will be considered as such by reference to the interpreter's intuitions on the matter*. The feature of rationality most tractable in the clinic may be logical coherence. Dennett is not committed to coherence as the basic feature of rationality but acknowledges its import.[43] In *Real Patterns*[28] and *Making Sense of Ourselves* it is coherence that ensures a detectable pattern for interpretation:

> So even in a case of cognitive dissonance, where the beliefs we attribute are not optimal by anyone's lights, the test of rational coherence is the preponderant measure of our attributions.[44]

Incoherence is not merely the absence of coherence but "blatant logical inconsistency."[45] Humans need not be fully consistent at all times. However, *when inconsistency is brought to one's attention the belief-desire set should be modified to maximise consistency*. If inconsistency is not eradicated then the interpreter is at a loss how to proceed. *Sustained inconsistency destabilises and undermines the ascription of beliefs and desires,* and so *the interpreter will prefer to explain speech and behaviour through the physical stance*. Where beliefs and desires cannot be ascribed *the interpreter will struggle to predict the other's actions and behaviours*. Indeed, failure to predict indicates the intentional stance is inapplicable.

Dennett has considered his theory of the intentional stance in relation to the concept of personhood.[46] He argued that personhood consists of six hierarchical layers; being an intentional system constitutes the base with consciousness at the apex. This implies that where rationality cannot be granted the conditions for personhood are unmet.

> [O]ur assumption that an entity is a person is shaken precisely in those cases where it matters: when wrong has been done and the question of responsibility arises. For in these cases the grounds for saying that the person is culpable (the evidence that he did wrong, was aware he was doing wrong, and did wrong of his own free will) are in themselves grounds for doubting that it is a person we are dealing with at all.

Thus, where irrationality is detected, *attribution of full personhood is withdrawn with implications for agency, responsibility, and related concepts*.

SUMMARY

Dennett has developed a sophisticated and influential account of how we understand and interpret one other. He has been explicit that some instances of mental disorder are

uninterpretable from the intentional stance. This has the consequence of denying belief and desires to that person, at least those that pertain to the symptoms in question. However, Dennett's bold claims about how mental symptoms should be considered from the intentional stance can now be explored in the clinic.

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DAVIDSON'S RADICAL INTERPRETATION

INTRODUCTION

Donald Davidson is considered to have been one of the most important philosophers of the late 20th Century.[1] All the more remarkable given he never wrote a book. Following a varied career that included writing radio plays, teaching WWII gunners to discriminate enemy aircraft at a distance, and experimental work on Decision Theory,[2] he began in his forties to publish the philosophical essays on the philosophies of mind, action, and language that were to bring him almost immediate regard. His first major essay, *Action, Reasons, and Causes,*[3] sought to refute the Wittgensteinian picture, popular at the time, that reasons cannot be causes for action because they lack the law-like nature of true causal explanation. Davidson weakened the concept of causation in the physical sciences and instead argued that the "reason for an action is its cause."

> When we ask why someone acted as he did, we want to be provided with an interpretation. His behaviour seems strange, alien, outré, pointless, out of character, disconnected; or perhaps we cannot even recognise an action in it. When we learn his reason we have an interpretation, a new description of what he did which fits into a familiar picture.[4]

What marked Davidson's work as significant was his development of a comprehensive philosophical system; his philosophies of mind, action, and language cohere and support one another. His theory of meaning has been so influential for it employed the rigour of analytic philosophy in a domain previously considered formally untameable. It is important to the present study because he provided an explicit programme for understanding another's words called "radical interpretation." Although Davidson insisted radical interpretation is not a theory for how interpretation actually occurs but rather a claim "about what must be said to give a satisfactory description of the competence of the interpreter,"[5] more practically minded philosophers have nevertheless applied it to real problems. Banner & Szmukler,[6] for instance, drew on radical interpretation to expose the normativity inherent to determinations of decision-making capacity, contrary to advice in the Mental Capacity Act 2005 for clinicians to be disinterested assessors. Simon Ervine[7] contrasted a Davidsonian

approach to understanding psychotic symptoms with the methods of philosophically inclined psychiatrists R.D. Laing and Silvano Arieti. Ervine concluded that the latter two explained away what is most in want of an explanation: the apparent irrationality of "madness."

Anomalous monism, Davidson's philosophical theory of mind,[8] is an attempt to reconcile the physical basis of the mental with its autonomy. Although mental states are identical to brain states, no deterministic laws govern the former. Instead, the mental realm is constrained by the rules of rationality, which has no counterpart in physical descriptions of the world. There are parallels with Jaspers here.[9] Mental states are meaningful and operate in accordance with completely different laws to the physical world; for Davidson these involve rationality whereas for Jaspers mental states are regulated by "internal causality." *Contra* Davidson, however, Jaspers considered internal causality merely analogous to its physical counterpart, "indicating the unbridgeable gulf between genuine connections of external causality and psychic connections."[10] Correspondingly, both held that interpretation of the other could fail, with catastrophic consequences for the would-be agent.

> We have no trouble understanding small perturbations against a background with which we are largely in sympathy, but large deviations from reality or consistency begin to undermine our ability to describe and explain what is going on in mental terms.[11]

Davidson, like Jaspers, attributed *de novo* beliefs and desires to non-rational causal processes.

> In the case of irrationality, the causal relation remains, while the logical relation [to other beliefs/desires] is missing or distorted… Many desires and emotions are shown to be irrational if they are explained by mental causes that are not the reasons for them.[12]

This chapter aims to develop an understanding of Davidson's theory of meaning and interpretation. There are, as Davidson himself noted, difficulties with the "empirical interpretation" of his model.[13] Nevertheless, he argued that something like it may be how

we do interpret in practice.[14, 15] First, a route will be mapped from his conception of mental holism through to his understanding of truth, which Davidson considered an approximation of meaning. Next, the constraints on meaning that facilitate interpretation are presented. Thus the "principles of charity" will be elucidated, which involves assuming the subject of interpretation is, to some degree, rational. The chapter concludes with a discussion on the application of Davidson's important and influential ideas in the interpretation of neuropsychiatric patients.

THEORY OF MEANING

HOLISM AND TRUTH IN RADICAL INTERPRETATION

One appreciates the boldness of Davidson's radical interpretation by considering its epistemic commitments: interpretation can proceed despite the interpreter having no prior knowledge or theory regarding the mental state or language of the subject of radical interpretation. Even aliens speaking Saturnian are in principle interpretable. Such exotic and extreme scenarios are clarifying devices. Even monolingualism poses an obstacle to interpretation; for why assume that the language spoken is the same? Perhaps this assumption is mistaken.[16] Complicating matters further, Davidson was convinced that thought and language are holistic. Belief that "the gun is loaded" depends on beliefs about ammunition, the gun as a weapon, the intransience of objects and an infinite number of interdependent beliefs.[17] Some philosophers of language have argued for the primacy of either thought or language, using one to gain purchase on the other. However, for Davidson, thought and language stand or fall together: "We should think of meanings and beliefs as interrelated constructs of a single theory."[18] One can only understand another's speech act ("I want some chips!") by simultaneously attributing to him mental states such as belief ("Chips will sate my hunger") and desires ("I wish my hunger sated.")

> We cannot hope to attach a sense to the attribution of finely discriminated intentions independently of interpreting speech […] interpreting an agents intentions, his beliefs, and his words are parts of a single project, no part of which can be assumed to be complete before the rest is.[19]

> If one thought logically entails another, or provides a degree of rational support for it, the same logical and confirming relations hold between the sentences that express that thought.[20]

The problem, therefore, is to break into this circle without knowing either the meaning of utterances or the content of mental states. Davidson claimed this is possible because the content of thought is propositional in nature and propositions by definition are either true or false; they have truth-conditions. It does not matter whether or not the proposition is true or false, so long as the truth conditions can in principle be stated. The truth conditions are known even for patent absurdities such as, "The moon is made of cheese." Knowing the truth conditions of propositions necessitates already possessing the concept of truth. This, for Davidson, indicated that truth is elementary to all thought and language; without it we would have no concepts at all.[21]

> Truth is one of the clearest and most basic concepts we have, so it is fruitless to dream of eliminating it in favour of something simpler or more basic.[22]

> A speaker holds a sentence to be true because of what the sentence (in his language) means, and because of what he believes.[23]

Truth, therefore, is the route to meaning.

TRUTH AND MEANING

Truth delivers meaning, or something approximating it, because to know the conditions for the veracity of a statement is to know what it means. To take the classic Davidsonian example (borrowed from Alfred Tarski[24]), knowing what makes the sentence "snow is white" true is to know what it means. Much of the appeal of Davidson's theory is explained by his modifying Tarski's truth theorem, considered one of the most important discoveries in logic of the 20th Century.[25] According to Tarski, the truth theorem is applicable only to formalised languages such as found in logic and mathematics, but Davidson adapted it for use in the

interpretation of natural language. However, whereas Tarski sought to define truth, Davidson considered the concept of truth to be inherent.

> A theory of truth entails, for each sentence *s*, a statement of the form "*s* is true if and only if *p*" where in the simplest case "*p*" is replaced by "*s*". Since the words "is true if and only if" are invariant, we may interpret them if we please as meaning "means that."[26]

Without digressing into Tarski's work, it is nevertheless important to appreciate how it differs from Davidson's. When Tarski states "*s* is true if and only if *p,*" he is providing the conditions of truth for the sentence "*s*" in an "object language," such as mathematics, by providing a translation of it as "*p*" in a richer "metalanguage". The need for a metalanguage arises because Tarski proved that truth could not be defined for a language within itself. In providing the conditions for truth, Tarski took as unproblematic the translation of "*s*" into "*p.*" Davidson, in pursuit of translation from an "object language" such as German into a metalanguage, say English, instead took truth as unproblematic. Whilst not every statement is truthful ("I am a knight-errant!") the vast majority of assents and dissents do correspond to beliefs ("That is a tree." "No that's not a dog, it's a cat.") One's attitude towards a statement is observable; interpreters observe the assents and dissents even when ignorant of the statement's meaning. Interpretation proceeds by establishing those sentences that both interpreter and subject consider true and false. Agreement on truth and falsity initiates the construction of a theory of interpretation.

> [T]he aim of theory will be an infinite correlation of sentences alike in truth. But […] the theory-builder must not be assumed to have direct insight into likely equivalences between his own tongue and the alien. What he must do is find out, however he can, what sentences the alien holds true in his own tongue (or better, to what degree he holds them true.) The linguist then will attempt to construct a characterisation of truth-for-the-alien which yields, as far as possible, a mapping of sentences held true (or false) by the alien on to sentences held true (or false) by the linguist.[27]

> When we consider the constraining need to match truth with truth throughout the language, we realise that any theory acceptable by this standard may yield, in effect, a useable translation manual from object language to metalanguage. The desired effect is standard in

> theory building: to extract a rich concept (here something reasonably close to translation) from thin bits of evidence (here the truth values of sentences) by imposing a formal structure on enough bits.[28]

Davidson, though no behaviourist, took behaviour to be the public evidence from which a theory of interpretation is constructed. However, the range of possible interpretations must somehow be constrained, as those "thin bits of evidence" could be compatible with a plethora of conflicting theories.

PRINCIPLES OF CHARITY

The principles of charity, so called because they demand the interpreter be generous in her understanding of the other, constrain interpretation by endowing the subject with basic rationality. This endowment is an assumption: without rationality, there is no interpretation.

> The possibility of understanding the speech or actions of an agent depends on the existence of a fundamentally rational pattern, a pattern that must, in general outline, be shared by all rational creatures.[29]

Charity consists of two principles, *coherence* and *correspondence*. Coherence requires the interpreter discover an internal logical consistency among the beliefs and desires (and hence language) of the subject for interpretation. Correspondence requires the subject be granted mainly true beliefs about the world.

PRINCIPLE OF COHERENCE

Coherence is a consequence of the holism of thought and language. Since beliefs derive their content from their place within the network, each belief must stand in some logical relation to its neighbours and truth, which Davidson holds so fundamental a concept, imposes a logical constraint. For example, it is not possible to believe that *p* is both true and false simultaneously (negation), while some beliefs entail others (logical consequence.)

> [W]e take it as a constraint on possible interpretations of sentences held true that they are logically consistent with one another.[30]

> [T]here is no giving the truth conditions of all sentences without showing that some sentences are logical consequences of others; if we regard the structure revealed as deep grammar, then grammar and logic must go hand in hand.[31]

So interpretation is constrained by projecting a rational pattern onto the subject's beliefs – language and belief will conform to the same patterns due to their holism – that by-and-large concurs with our own basic rules of rationality. This agreement matters. Where basic rules are routinely flouted there is internal incoherence, hence we cannot get anywhere with our interpretations.

> If we fail to discover a coherent and plausible pattern in the attitudes and actions of others we simply forego the chance of treating them as persons.[32]

Coherence also imposes a strong constraint on behaviour: one should not act contrary to one's beliefs or to thwart one's desires. The standards of rationality are plastic rather than rigid and incorporate rational decision theory, rules of logic, and inductive reasoning. What counts as inexplicably deviant cannot be fixed in advance, but an acceptable rule of thumb is: "All thinking creatures subscribe to my basic standards or norms of rationality."[33] This is, Davidson assured, not chauvinism on his part because all "thinking creatures" must conform to the same basic rules to have any thoughts at all. Considering the other as rational, in terms of coherence, is less an assumption granted charitably but more a condition of treating him as an agent, who thinks, speaks, and acts. The charity comes in seeking the greatest possible coherence in the speaker's utterances.

> [J]ust as we must maximise agreement, or risk not making sense of what the alien is talking about, so we must maximise the self-consistency we attribute to him, on risk of not understanding *him*.[34]

This is the first step in developing a theory of interpretation. It imposes a rational pattern on the speaker that maximises consistency and coherence among the beliefs and sentences expressed. However, another step is required, which grants that the speaker is by-and-large correct in his beliefs about the world.

PRINCIPLE OF CORRESPONDENCE

Perceptual features of the world provide a next step in forming a "fit" between the speaker and his interpreter. As sentences about external events will be held true sometimes and not at other times (for example: "That is a rabbit" is true only when a rabbit is visible), this gradually enables the interpretation of names and other discoverable features of the environment, like "tall" and "beauty."

> What seems basic is this: an observer finds a regularity in the verbal behaviour of the informant which he can correlate with events and objects in the environment.[35]

In order to correlate objects in the environment with words we must grant the speaker generally to be correct in his assertions. Indeed, we must grant that most of the speaker's beliefs are true.

> Charity is forced on us; whether we like it or not, if we want to understand others, we must count them right in most matters.[36]

> The nature of correct interpretation guarantees both that a large number of our simplest beliefs are true, and that the nature of these beliefs is known to others.[37]

Correspondence is high for sentences about perceptual experiences, as we are constructed to react similarly to salient features in the environment. These points of correspondence anchor the development of constructs less directly observable, such as emotional states, or theoretical concepts like natural selection. Again, disagreement between speaker and

interpreter makes interpretation problematic. Not though to the same extent because logical inconsistency as the interpreter can, to some degree, develop ad hoc hypotheses to account for the lack of agreement. Davidson might be accused of having overstated human rationality in his theory of radical translation but he was aware of the need to account for apparent instances of irrationality. This is less problematic for him than might at first appear. For Davidson, irrationality is not the absence of rationality but a deviation from rationality that can only be described from the purview of rationality.

> We often, and justifiably, find others irrational and wrong; but such judgments are most firmly based when there is most agreement.[38]

> Widespread agreement is the only possible background against which disputes and mistakes can be interpreted. Making sense of the utterances and behaviour of others, even their most aberrant behaviour, requires us to find a great deal of truth and reason in them.[39]

It is only because there is so much agreement between individuals that irrationality is perceptible.

INDETERMINACY OF MEANING

Even with a theory of interpretation in place that maximises agreement and consistency some other theory can yet be envisaged that fits the data equally well. For instance, one could interpret a speaker as naming the animal whenever he says "rabbit" on seeing one hop into view. However, it could equally well mean "dinner," "hopping thing," or "large ears." Indeed, any number of alternatives. Davidson, therefore, anticipated some indeterminacy of meaning.

> A theory for interpreting the utterances of a single speaker, based on nothing but his attitudes towards sentences, would, we may be sure, have many equally intelligible rivals, for differences in interpretation could be offset by appropriate differences in the beliefs attributed.[40]

However, Davidson was not overly troubled. The indeterminacy is not of the degree suggested by WVO Quine who thought it fatally undermined any and all attempts at interpretation (or in Quine's preferred term, translation.) For Quine, there were just too many possible translations available that account for the evidence equally well.[41] There are two reasons for Davidson's more sanguine view. Firstly, he recognised that language exists within a community of speakers, so a single theory of interpretation built on evidence from a community will have multiple data points. Hence the number of possible interpretations greatly reduced. A theory so constructed can be applied to the interpretation of individuals within that community making idiosyncrasies of belief easier to interpret as such. Secondly, indeterminacy is less of a problem for Davidson than Quine because the Tarski-style truth conditions and Davidson's assumption of rationality impose greater constraint on possible interpretations than Quine had supposed possible.[42]

> When all the evidence is in, there will remain, as Quine has emphasised, the trade-offs between the beliefs we attribute to a speaker and the interpretations we give his words. But the resulting indeterminacy cannot be so great but that any theory that passes the tests will serve to yield interpretations.[43]

Davidson also took interpretations to be subject to change as evidence accumulates, always seeking to optimise coherence and consistency. Whilst each interpretation of meaning is open to revision, it is nevertheless still a valid interpretation. Relatedly, there can be differences between the meaning of the words used and the speaker's intended meaning. Davidson discussed how an interpreter has little difficulty understanding less than perfect utterances and even heavily malapropistic talk: e.g. "We need a few laughs to break up the monogamy."[44] Success is achieved because we bring to interpretation a prior theory based on the speaker's age, gender, social status, ethnic grouping etc.

> As the speaker speaks his piece the interpreter alters his theory, entering hypotheses about new names, altering the interpretation of familiar predicates, and revising past interpretations of particular utterances in the light of new evidence.[45]

This new theory is a co-creation between interlocutors. If one seeks comprehension he should appreciate how he is being interpreted by the other; and if he uses malapropisms, idiosyncratic meanings of particular words, uncommon metaphors and the like, he had better leave clues sufficient for their interpretation.

> A speaker cannot intend to mean something by what he says unless he believes his audience will interpret his words as he intends.[46]

IN THE CLINIC

Davidson's theory of meaning lends itself to application in the clinical setting. Attempting to understand the meaning of a delusion that strikes us as bizarre, impossible or absurd could be seen as analogous to interpretation of an exotic tribe or alien visitor. Although clinician and patient commonly share a language, it appears the meaning of their utterances is not shared when, for instance, the patient states, "I am dead." The epistemic position of the radical interpreter, with no prior knowledge or theory of what the patient might mean or believe, seems a favourable place to start. Significant themes are emphasised by italics.

First and foremost, the principles of charity, given they are by definition rule-like and constrain interpretation, are obvious candidates for consideration. Due to holism of the mental, Davidson was explicit that *lack of coherence impedes interpretability*. Indeed, *incoherence in the network of putative beliefs and desires and the like undermines one's ability to attribute any mental states whatsoever*. So a person who is taken to be flouting the basic rules of logic – negation (can't believe both *p* and not-*p* simultaneously), entailment (*x* is a bachelor, therefore *x* is a man), transitivity of preference (if one prefers *x* to *y* and *y* to *z*, one should also prefer *x* to *z*), law of identity (*p* is *p*) – will pose serious difficulties for interpretation. *Carers will use themselves as the standard of logic against which irrationality is adjudged*.

Correspondence constrains interpretation, as the interpreter will also hold most of the speaker's beliefs true. *Where there is disagreement, the interpreter will modify either the*

content of the beliefs ascribed or the precise meaning of the speaker's words to optimise coherence.

> We do this sort of off the cuff interpretation all the time, deciding in favour of reinterpretation of words in order to preserve a reasonable theory of belief.[47]

Rather than forming a fixed theory, an interpreter may well prevaricate between various interpretations, but each one serves to maintain the correspondence of held-true beliefs. Although such interpretative difficulties are a challenge, *the failure of correspondence is not taken to be so catastrophic to interpretation as flouting the principle of coherence*.

> No factual belief by itself, no matter how egregious it seems to others, can be held to be irrational. It is only when beliefs are inconsistent with other beliefs according to principles held by the agent himself—in other words, only when there is an inner inconsistency—that there is a clear case of irrationality.[48]

Where the principles of charity seem to fail there will be increased indeterminacy of interpretations, hence, the number of contradictory interpretations will proliferate. Additionally, there will be a lack of evidence on which to decide between potential interpretations. *One anticipates that the interpreter in this situation will prevaricate between possible interpretations and none at all*. This indeterminacy will be both troublesome and troubling. *Interpreters will doubt whether the speaker believes anything at all, or can be considered to entertain desires and wishes*. In the severest degree, *the very personhood of the speaker is thrown into doubt*. He may be viewed as lacking agency, will, self-determination, morality, etc.

SUMMARY

In conclusion, we have seen that Davidson has provided a distinctive approach to the problem of interpretation when it is not clear what a speaker means by his words. This

model has been considered in relation to psychiatry but its implications and predictions have not, to the author's knowledge, been evaluated in discussion with actual patients and their foremost interpreters, those who care for them.

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WITTGENSTEIN'S AGREEMENT & CERTAINTY

INTRODUCTION

Ludwig Wittgenstein's fascination with the philosophy of language is well known; his interest in psychiatry, less so. It did not extend to a sustained philosophical engagement, but he did divert one of his students, Maurice Drury, from an ecclesiastical path towards psychiatry. Wittgenstein is rumoured to have contemplated this career change for himself.[1] He visited psychiatric patients at St Patrick's Hospital during his stay in Dublin, prompting him to remark of one involuntary resident: "I find this man much more intelligent than any of his doctors."[2] He was also generous with his advice to the young Drury, reminding him to make time to listen to his patients. More pointedly, he declared:

> You should never cease to be amazed at symptoms mental patients show. If I became mad the thing I would fear most would be your common-sense attitude. That you should take it as a matter of course that I should be suffering from delusions.[3]

For Drury's birthday Wittgenstein sent him a copy of Freud's *Interpretation of Dreams*, opining, "Here at last is a psychologist who has something to say."[4] He was impressed by Freud's attempt to decode psychiatric symptoms and reinstate meaning.

> Freud's idea: In madness the lock is not destroyed, only altered; the old key can no longer unlock it, but it could be opened by a differently constructed key.[5]

However, he came to regard Freud as having constructed a "powerful mythology,"[6] a simulacrum of the scientific method.

> Freud's fanciful pseudo-explanations (precisely because they are so brilliant) perform a disservice. Now any ass has these pictures to use in "explaining" symptoms of an illness.[7]

Wittgenstein's last work, *On Certainty* (*OC*),[8] is a series of interconnected notes rebutting radical scepticism. *OC* does not directly address the topic of mental disorder but the frequency of references to related themes is intriguing. Indeed, psychopathology is implicated to a greater or lesser degree in 61 of the 676 paragraphs. Many statements in *OC* appear to suggest the later Wittgenstein considered mental disorder as somehow *other* and less understandable than he had previously.

> If Moore were to pronounce the opposite of those propositions which he declares certain, we should not just not share his opinion: we should regard him as demented. §155[9]

> For mightn't I be crazy and not doubting what I absolutely ought to doubt. §223[10]

In recent years, *OC* has influenced a number of philosophers' writings on the nature of delusion. John Campbell's paper *Rationality, Meaning, and the Analysis of Delusion*[11] is an important and influential case in point. The bulk of the paper aims at refuting the currently popular theory that delusions are caused by an abnormal perceptual experience, often called the "empiricist" approach. The sufferer seeks an explanation for this abnormal perception, and the delusion's content is provided by this explanation. Delusions are therefore viewed as rational response to the anomalous perception. Campbell invokes *OC* to offer a fundamentally different model. In his self-styled "rationalist" account, the fault is said to lie in the background beliefs (A.K.A. framework beliefs) that Wittgenstein had argued form the basis for all knowledge. Delusional beliefs are somehow – Campbell's explanation is underspecified in his paper – included within the sufferer's unreflective indubitable background. Crucially, such a shift in these background beliefs "destabilises the meanings of the terms used."[12] Hence, the Cotard's patient who claims to be dead should not be taken quite literally. He doesn't really *mean* what he says. At the opposite extreme, Wittgenstein's philosophy has been used to argue that delusions are indeed meaningful. As discussed in the *Introduction*, Louis Sass employed a rather different aspect of Wittgenstein's work to construct meaning-laden interpretations of Paul Schreber's seemingly inscrutable thicket of delusions.[13] Wittgenstein's philosophy of language has thus been employed to argue that delusional content both is and is not meaningful.

It should be noted there is disagreement as to the whether or not Wittgenstein's theory is foundational. Theories of epistemology are either foundationalist or coherentist; that is, knowledge is either founded in some infallible certainties or it is the coherence of the whole structure that justifies individual knowledge claims.[14] Avrum Stroll, for instance, considers *On Certainty* definitively foundational.[15] However, the text suggests a different reading. Consider, "When we first begin to *believe* anything, what we believe is not a single proposition but a whole system of propositions. (Light dawns gradually over the whole) §141"[16] and "I have arrived at the rock bottom of my convictions. And one might almost say that these foundation-walls are carried by the whole house. §248"[17] Wittgenstein therefore offers a more radical vision of epistemology,[18] going beyond traditional versions by founding knowledge in our practical acting in the world.

The purpose of this chapter is to formulate some key Wittgensteinian themes that bear directly on the question of meaning in psychopathology. These themes are interwoven but for clarity, each is explicated in turn: i) meaning is use according to a rule; ii) agreement in judgment and; iii) hinge propositions. Explication of themes will be supported by textual evidence from *Philosophical Investigations*[19] (*PI*) and *On Certainty* (*OC*). The chapter concludes with a practical proposal for exploring these themes in the IPA interviews with patients and carers.

WITTGENSTEINIAN THEMES

MEANING IS USE ACCORDING TO A RULE

In *PI*, Wittgenstein challenged a dominant strain in the philosophy of language: words stand for an entity of some sort and that entity is the meaning of the word (e.g. for Augustine words name objects in the world; for Locke the word stood for an "idea"; for contemporary philosophers, a "mental representation.") This view of language seems so obvious that it beguiles us and leads us into all manner of conceptual confusions:

> The problems arising through a misinterpretation of our forms of language have the character of *depth*. They are deep disquietudes; their roots are as deep in us as the forms of our language and their significance is as great as the importance of our language. §111[20]

Wittgenstein saw that his own early philosophy had fallen into this same trap:

> A *picture* held us captive. And we could not get outside it, for it lay in our language and language seemed to repeat it to us inexorably. §115[21]

The problems with taking words as naming objects, whether internal or external, are twofold. Firstly, many words just do not seem to name anything at all. To illustrate, Wittgenstein considered what is named by the words "this" and "that" and observed, "we do the most various things with our sentences §27."[22] Secondly, Wittgenstein began *PI* by quoting Augustine's claim to have learnt various names by observing his parents point and utter the name. However, Wittgenstein doubted such ostensive definition could suffice to teach a language; how is the child to know what is being named? Suppose a cup is pointed to and "named." The child could take "cup" to mean the colour, the shape, that particular instance of the object, the act of pointing, or any number of other things.

> That is to say: an ostensive definition can be variously interpreted in *every* case. §28

> So one might say: an ostensive definition explains the use – the meaning – of a word when the overall role of the word in language is clear [….] One has already to know (or be able to do) something in order to be capable of asking a thing's name. But what does one have to know? §30[23]

The answer: only someone who knows how to use names already has the ability to ask of one. This locates language within a practice and the meaning of a word (and sentence) relates to how it is used in the community.

> For a large class of cases – though not for all – in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language. §43[24]

Not every instance of using a word is legitimate, however. It can be used correctly or incorrectly; otherwise there could be no such thing as meaning anything by a word. In Carroll's *Through the Looking Glass*, Humpty Dumpty is considered perverse for his idiosyncratic use of words. It is impossible to understand what he means by his words as uses them however he pleases.[25] But correct use, and therefore meaning, is rule-governed. So the question of what it is for a word to have meaning is bound up with the question of what it is to follow a rule**.** What is it to act or talk in accord with a rule and how is one to tell when the rule has been transgressed? What fixes the rule and its correct application over time and between people? Wittgenstein considered then rejected various alternatives. He considered whether an image in the mind upon understanding a word (e.g. the mental image of a "cup") could ensure that all future applications of the word accord but concluded there is nothing intrinsic about an image that forces any one particular interpretation of it. Hence, an image cannot determine between correct or incorrect application of a rule and the ability to correctly interpret the image stands in need of explanation just as the word does. Also, he considered whether it is how the rule was *meant* that enables it to guide future use. He took as his example the correct continuation of an algebraic rule:

> Your idea, then, is that you know the application of the rule of the series quite apart from remembering actual applications to particular numbers. And you will perhaps say: "Of course! For the series is infinite and the bit of it that I can develop finite." §140[26]

Wittgenstein illustrated this with a child being taught to carry on the series of even numbers. When the child reaches 1000 he continues 1004, 1008, 1012…. Although the teacher never explicitly thought the child should continue the series 1000, 1002, 1004, etc., it is still what she had *meant* her pupil to do. But Wittgenstein then went on to explain that there is something wrong with this option too. What is meant now cannot fix all future applications of a rule because how it was meant underdetermines future applications and merely shifts the problem onto determining what exactly was meant. The past instances of applying the rule can be compatible with any number of interpretations of it now. Similar such rejection

of rules being *dispositions* to act in a certain way, *grasping* all future applications in a flash, and the rule as represented in tabular form brought Wittgenstein to his famous statement of the problem:

> This was our paradox: no course of action could be determined by a rule, because any course of action can be made out to accord with the rule. The answer was: if *any* action can be made out to accord with the rule, then it can also be made out to conflict with it. And so there would be neither accord nor conflict here. §201[27]

And his equally famous resolution of the paradox denying the need to interpret rules at all:

> What this shews is that there is a way of grasping a rule which is *not* an *interpretation*, but which is exhibited in what we call "obeying the rule" and "going against it" in actual cases… §201
>
> And hence also 'obeying a rule' is a practice. §202[28]

Following a rule, hence meaning, is to be engaged in a practice. And the rule is constituted through practice, not predetermined beforehand. There is nothing deeper or more fundamental than the practice itself. We are brought into a practice through training, the use of examples, being told where we have gone right and gone wrong. Once inculcated into a particular practice it is this alone that determines whether someone does or does not follow a rule. There can be no appeal to deeper causes or explanations.

> "How am I able to obey a rule?" – if this is not a question about causes, then it is about the justification for my following the rule in the way I do.
> If I have exhausted the justifications I have reached bedrock, and my spade is turned. Then I am inclined to say: "This is simply what I do." […] §217
>
> When I obey a rule, I do not choose.
> I obey the rule *blindly*. §219[29]

A practice must be sharable with others; there cannot be a practice that is private to just one person. To understand another person necessitates sharing practices. The concepts of rule and that of agreement are closely related; understanding the one means understanding the other. And it is our agreement in judging that enables us to distinguish between conforming to a practice and failing to do so.

> If language is to be a means of communication there must be agreement not only in definitions but also (queer as this may sound) in judgments. §242[30]

AGREEMENT IN JUDGMENT

Determining whether a rule is being followed correctly or not is a matter of judgment. A community applies the rules of language in a standard way because there is an agreement in such judgments within the community. The agreement Wittgenstein averred would, one supposes, arise from our sharing biological characteristics, a cultural history and common practices in a relatively stable world. A community of language users agreeing on a particular concept does not make it objectively true or necessary but rather determines what we conceive to be true. Communication presupposes agreement. So when our judgments diverge, communication, and therefore shared meaning, falters. For instance, it is possible for one to coin a neologism for a novel event or object, so long as the use displays regularity discernable to others; there is agreement about correct and incorrect application. If the rule appears random it cannot be learnt so the neologism has no meaning. Complete agreement in each and every judgment is not required, but if others can discern the regularity then one's actions and words are understandable. This brings out an important Wittgensteinian idea:

> "So you are saying that human agreement decides what is true and what is false?" – It is what human beings *say* that is true and false; and they agree in the language they use. This is not agreement in opinions but in form of life. §241[31]

A feature of this "form of life"[32] is a certainty manifest in action, which is explored further in Wittgenstein's *OC*.

HINGE PROPOSITIONS

While *PI* was concerned with developing an understanding of language and meaning, *OC* took epistemology as its main focus. How can knowledge be defended against the radical sceptic's doubts? Indeed, how does one even know that, "This is my hand"? – the problem with which OC begins.

> If you do know that *here is one hand*, we'll grant you all the rest. §1[33]

If that can be established with certainty so too can other knowledge claims. Wittgenstein maintained that there are things – often called hinge propositions in the literature[34] – of which we are certain. Upon standing one does not query the existence of one's feet. One's conviction is revealed in the act of rising. Such certainties are beyond doubt and in fact doubting only occurs when some things are first taken for granted. Questioning the reality of the Higgs boson requires certainty that, for instance, subatomic particles do exist. So what seems to ground knowledge is our *acting* with certainty, a theme that unites *PI* and *OC*. Just as *OC* begins with the assertion "here is one hand" (the very symbol of human activity), the first language-game described by Wittgenstein in *PI* §2 is a builder instructing his assistant. Consider again §217 from *PI*:

> If I have exhausted the justifications I have reached bedrock, and my spade is turned. Then I am inclined to say: "This is simply what I do." §217[35]

Similarly, in *OC*:

> "I know all that." And that will come out in the way I act and in the way I speak about the things in question. §395[36]

> "In the beginning was the deed." §402[37]

The latter, Wittgenstein's quoting of Goethe's *Faust*. Hinge propositions ground knowledge but are themselves taken on trust, unconscious, and unreasoned. Some are learnt through inculcation (e.g. "We learn with the same inexorability that this is a chair as that 2x2=4." §455[38]) while others are determined by our inherited nature. They are, in Wittgenstein's idiosyncratic use of the term, grammatical, in that they operate as rules for structuring thought. These "grammatical" rules are not represented in the mind but are instead embedded in practice:

> There is always the danger of wanting to find an expression's meaning by contemplating the expression itself, and the frame of mind in which one wants to use it, instead of always thinking of the practice. §601[39]

When pointing to a red pillar-box to demonstrate a token of "red" to a young child, one forges an unassailable rule for the correct use of that word, bringing him into a shared practice. Once imbibed, such rules enable doubt but cannot themselves be doubted in normal circumstances. However, it may again make sense to say, "That is red" during a special procedure such as eye examination. Otherwise, "grammatical" rules – the hinges – remain unexpressed. Hinge propositions taken as a whole form a coherent structure, and it is the entire hinge proposition system that is taken on rather than individual hinges in piecemeal. Recall that: "Light dawns gradually over the whole. §141"[40]

Hinges have been categorised into differing types of equal import by Mayol-Sharrock.[41] The types of hinges are:

a. Universal
b. Local

c. Personal

d. Linguistic

a. Universal hinges – such as "I have a body," "The world exists" – are shared with all other humans and could not at any time be relinquished: they constitute the bounds of the human form of life. Mayol-Sharrock includes certainty in the existence of other minds and the rejection of transmogrification and human resurrection as other Universal hinges, although the list is endless. However, repudiation of any of the aforementioned hinges has correlate with delusional beliefs described in psychiatric textbooks.[42]

b. Local hinges characterise culturally specific frameworks of knowledge. Thus, the hinge belief that the earth is a small sphere orbiting the sun is local to a particular time and place and coherent within a system of knowledge. Hinges local to a group are potentially mutable despite being held with the certainty of universal ones. For example, the cultural hinge "all sinners go to Hell" was considered as certain as the universal hinge "I have two hands" in medieval Europe. A local hinge may puzzle someone of a different culture because the whole framework in which it is embedded differs. Some delusions might represent distortion of local hinges, as cultural appropriateness constitutes one of the criterions for delusion.[43]

c. Personal hinges relate to the individual only. "I am sitting at my desk" is clearly personal rather than local or universal, yet still it cannot be doubted. Mayol-Sharrock sub-divided personal hinges into autobiographical and perceptual. The former relate to one's personal history while the latter concern perceptions, internal states, and spatio-temporal position. Amnesia, confabulation, and delusional memory represent problematic autobiographical hinges; hallucination and disorientation to time, place, and person indicate fault with perceptual hinges. Of disorientation to person, Wittgenstein wrote:

> If my name is *not* L.W., how can I rely on what is meant by "true" and "false"? §515[44]

d. Linguistic hinges are engrained rules, such as the correct use of "red." What has been learnt is a practical mastery of language. Rare words may cause one to pause and think but common words are known with certainty. An adult who suddenly misuses words like "red" will cause others to conclude there must be a visual impairment. Once this is discounted, others will no longer understand what is meant by his future applications of the word "red." It is perhaps such a case that Campbell has in mind when he states that the Capgras sufferer uses the word "wife" in a manner incomprehensible to interlocutors.

In summary, hinge propositions are a network of interconnected certainties about the world and ourselves that ground knowledge and action. Some are innate, others learnt; some are universal, others local to one's culture and oneself. And the certainty of hinge propositions is intimately related to our facility to use language, judge in agreement with others, and to engage in a practice:

> But why *am* I so certain that this is my hand? Doesn't the whole language-game rest on this certainty?
>
> Or: isn't this "certainty" (already) presupposed in the language-game? Namely by virtue of the fact that one is not playing the game, or is playing it wrong, if one does not recognize objects with certainty. §446[45]

IN THE CLINIC

Wittgenstein's approach to meaning and certainty has appeal in the clinical encounter, and he must surely have considered such matters when conversing with patients during his visits to St Patrick's Hospital. Furthermore, his situating meaning and understanding within a community practice chimes with a motif in the anti-psychiatric literature: the "mad" are deemed un-understandable hence ostracised.[46] Although Wittgenstein did not develop an explicit theory of meaning, his writings do suggest various avenues for exploration in the clinical material. Again, these are emphasised by italics.

If, by Wittgenstein's lights, we are to understand someone's words (and actions) then he must employ those words in a standard fashion. Words of course change their meaning over time and across cultural and subcultural groups. But Wittgenstein insisted that a rule must be in principle learnable for the word to convey meaning. *The pattern of use should be consistent and discernable to others from the same linguistic community*. The close relationship between accordance with a rule and agreement is also of potential utility. Where there is disagreement in the usage of the words "blue" and "orange" it is unclear whether judgments diverge (you judge it to be blue, I judge it orange) or the rules of application differ. Hence, *failure to agree on judgments will manifest as an apparent absence of pattern or law-like regularity*. Is the move from difficulty with meaning to non-accordance with a rule or disagreement in judgment in any way helpful? Does it not merely shift the problem from one abstruse concept to another? This however misses the point. Wittgenstein intended to show that meaning is not some impenetrable extra-linguistic object but is simply part and parcel of our everyday linguistic competence. To be able to speak a language is, among other things, to know when words are misused.

While not exhaustive, the various hinges cited by Moore and Mayol-Sharrock provide a checklist of sorts to determine if the content correlates with a hinge proposition. Included in Moore's list are "There exists at present a living human body, which is my body. This body was born at a certain time in the past, and has existed continuously ever since, though not without undergoing changes… Ever since it was born, it has been either in contact with or not far from the surface of the earth; and at every moment since it was born, there have also existed many other things, having shape and size in three dimension"[47] and so on. Mayol-Sharrock, on the other hand, described universal, cultural and personal categories of hinge propositions. *It should be possible to compare psychopathological content against these lists to identify any correspondence*. Hinge propositions are normally unspoken, *so their expression should induce puzzlement in an audience*. A speaker who expresses doubt about a hinge should be met not merely with confusion but *his sanity called into question*.

Wittgenstein's holistic picture of hinge propositions leads perhaps to a further possibility. On the one hand, a localised alteration in hinges may cause a shift in the whole structure. If so, *someone who has undergone such an alteration will posses a system incommensurable with others*. Every word, sentence, and belief will mean something different to his peer and no

amount of talking will align the two systems. On the other hand, it is possible that – as Davidson discussed[48] – alteration in one localised area of the system causes changes in meaning in the surrounding area, but the whole system need not be affected. Systems are by nature conservative and *so change may be localised while the majority of the structure is preserved*.

Finally, unique to Wittgenstein was his discussion of the first-person subjective consequences of disruption to hinge beliefs. He intimated that *the person who doubts what once was certain would relinquish all judging*, for nothing can be relied upon. Alternatively, the *alteration may be outside awareness, so the subjective consequences less catastrophic but incommensurability is the major difficulty*. As Wittgenstein ventured: "We should feel ourselves intellectually very distant from someone who said this. §108"[49]

SUMMARY

Wittgenstein offers an account of meaning, if not a formal theory. Although, he is not infrequently invoked in theoretical discussions of psychopathology, there has to date been no investigation of his philosophical thinking in actual patients. This is a shame given that *On Certainty*, with its many references to mental disorder, may have been influenced by Wittgenstein's own experiences on psychiatric wards in Dublin.

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[47] Moore GE. A Defence of Common Sense. In *Philosophical Papers*, George Allen and Unwin Ltd, 1959, pp. 32-59.

[48] Davidson D. On the Very Idea of a Conceptual Scheme. In *Inquiries into Truth and Interpretation*. Oxford University Press, 2001, pp. 183-98.

[49] Wittgenstein, 1969, *op. cit.*, p. 17e.

OUTLINE OF HYPOTHESES TO BE TESTED

The three chapters above provided overviews of the three philosophies of meaning under consideration and concluded with some suggestions for how these might unfold in the clinic. The time has come to offer more categorical hypotheses from each theory to sequentially examine against the interview material. These are presented in *Results: Part B* under the following sub-headings:

Dennett's Intentional Stance theory

1. Does the patient believe what s/he ought?

The interview will be considered in terms of whether the patient does hold all the beliefs the reader thinks he or she ought to hold. Any beliefs held that ought not to be will be discussed explicitly. It is assumed the reader will largely agree with the author, as any such false-beliefs will be closer to the perceptual than conceptual sort, and it is acknowledged there is likely to be less agreement on the latter. Intertwined will be instances where the patient's carer has highlighted beliefs that she thinks he ought not hold.

2. Is the patient irrational?

There follows an exploration of whether the patient conforms to Dennett's vision of rationality when discussing the symptom. While it is acknowledged that Dennett is not wholly consistent himself on what exactly constitutes irrationality, the symptom will be compared to actual descriptions he has given of irrationality and un-interpretability.

3. Do others adopt the physical stance towards the symptom or person?

This question will principally be addressed to the carer interviews but the patients' interviews do also provide some clues as to how they are viewed by others. It is assumed that discussion of the symptom as signifying disease *simpliciter* represents a physical stance interpretation. Diminished or revoked personhood likewise indicates the intentional stance has been revoked.

Davidson's Radical Interpretation theory

4. Does the patient conform to the principle of coherence?

Similar to Dennett's vision of rationality but Davidson gave more detailed examples of coherence and incoherence that could be tolerated by radical interpretation. Again, the patient interviews are surveyed for actual instances of incoherence, both the logical sort that Davidson held as incompatible with rationality and the weaker quotidian kind. Carers also identified inconsistency so it their accounts were discussed in light of Davidson's examples.

5. Does the patient conform to the principle of correspondence?

The patient and carer interviews are examined to establish whether and where there are disagreements about the external world, which Davidson thought must largely correspond to ground interpretations of one another. It is similar to Dennett's ought although with a different emphasis. The radical interpreter must assume the object of interpretation largely reports true statements about the world. We consider whether this assumption is vindicated or not.

Wittgenstein's agreement and certainty "theory"

6. Are hinge beliefs implicated?

The chapter on Wittgenstein produced a list of hinge beliefs and some instances from psychopathology where these might be contravened. Statements made by patients and carers are reviewed and potential contravention of hinges described and the consequences discussed. Furthermore, we discuss whether new hinges are in operation rather than accepted hinge beliefs no longer operating as such.

7. Do judgements agree with others?

Agreement in judgement is likewise similar to Davidson's principle of correspondence. While the latter based his in epistemology it appears to be rules-based for Wittgenstein and more

far reaching too. His notion of agreement is prior to the distinction between truth and falsity; it concerns what counts as a reason or evidence.

8. What are the subjective consequences?

Wittgenstein's approach is unique in actually discussing how loss of certainty and sureness with regards hinge beliefs will impact the sufferer. This material is predominantly drawn from the patient interviews although carer's observations are of course also important here.

Now we have more precise and tractable questions in place we turn to the results of the analyses themselves. We begin with the primary IPA analyses and in *Results: Part B* complete the secondary theory-driven analyses.

THE MEANING OF NEUROPSYCHIATRIC THEORIES

INTRODUCTION

Before considering the cases from the perspective of the philosophies of meaning, it is necessary to survey the range of opinion concerning meaningfulness in the neuropsychiatric symptoms with which the cases present. This will demonstrate the diversity of opinion and illustrate some of the pertinent issues on which such debates turn. The survey will begin with Capgras' delusion, then visual hallucination, and finish with confabulation.

CAPGRAS' DELUSION

Capgras' delusion has an almost totemic status in the neuro-scientific understanding of psychopathology.[1, 2] The original paper[3] described *Mme M's* horrific enmeshment in a logarithmic expansion of doubles that reads more like a short story by Edgar Allen Poe than a medical case history. Following the death of two daughters and twin boys she became convinced her only remaining daughter had been abducted and replaced by an imposter, who in turn was replaced by another so over a four year period she encountered more than 2,000 doubles. Amidst this, she believed her husband had been murdered and another set in his place. The entire police force were duplicated on numerous occasions, hence her inability to secure justice. Likewise, the doctors in the hospital multiplied, each undermining the order of his predecessor. Explanatory models for this intriguing phenomenon seem to proliferate at a similar rate though it was Capgras himself who set the range of options. His initial proposal was strikingly similar to contemporary accounts:

> [S]ome faces that she sees with their normal features, the memory of which is not altered in any way, are nevertheless no longer accompanied by this feeling of exclusive familiarity which determines direct perception, immediate recognition.[4]

In a subsequent paper, however, he and co-author Carrette co-opted Freudian concepts. A young woman's delusion that her parents were imposters could then be conceived as a solution for an erotic attachment to her father.

THE PSYCHODYNAMIC MODEL

A favourite of the psychodynamic accounts holds that the delusion is a guilt-free expression of repressed animus by transferral onto another figure, while the cherished "real" object is absent. Thus, there is splitting and projection of the now overt hateful feelings on to the imposter.[5] Psychodynamic theories employ repression, regression, ambivalence, and depersonalisation to varying degrees, but have been criticised for being post-hoc, un-falsifiable, reliant on unobservable defence mechanisms, and unable to account for cases where the delusional content involves non-intimates, inanimate objects, and buildings.[6] Whatever the details of the psychodynamic explanation, they all share the principle that psychiatric symptoms are "reflections of unconscious processes that defend against repressed wishes and feeling."[7] Bolton and Hill[8] suggest that such explanations extend the allegedly universal human system for understanding and predicting others called folk psychology,[9] which bears similarity to Dennett's intentional stance. Behaviour is predicted and explained on the basis of the actor's beliefs about the world and desires for certain outcomes. However, in the psychodynamic approach, desires guiding behaviour may well be unconscious. Therefore, what appears in want of explanation – the delusion of an *alius* father – becomes readily understandable. Were it not for the hypothesised unconscious desire, the delusion would be unfathomable to ordinary folk; the connections between desire, belief, and action obscured.

THE PHENOMENOLOGICAL MODEL

The phenomenologists judge psychoanalysis overly quick to hypothesise unconscious desires,[10] while they too seek the restoration of meaning. The phenomenological approach claims:

> [T]o render manifest the manifest. It is to reveal to us how things appear to the subject or patient; and to do so in a way that clarifies, to the extent possible, the (sometimes paradoxical) coherence of the patient's world and life by showing the interdependence of different aspects and phases of her experiences and expression.[11]

Matthew Ratcliffe[12] had described a phenomenological theory of the Capgras delusion that aims to show how the delusion can be understood using everyday psychological concepts, criticising folk psychology in its current form as inadequate to the task. Central to his description is the loss of an "affective familiarity," a taken-for-granted background through which the world is experienced, particularly those objects we value. Following its loss, the sufferer no longer feels at home in the world and "there is a sense in which an 'absence,' a 'not' is part of the experience."[13] Thus, her altered experience of the world is uncanny. She directly perceives her husband as unfamiliar yet identical; the *alius* is seen *as* an imposter. According to Ratcliffe, due to its neglect of affect, folk psychology cannot account for the delusional content, but once introduced, the delusion becomes understandable without recourse to hypothecated defence mechanisms. This loss, however, leaves much in want of explanation. Even if everyday experiences of unfamiliarity do go some way towards understanding this uncanniness, the loss of affective familiarity itself remains unexplained. Also, why such a general experience should produce the relatively circumscribed focus upon intimates and the frequently bizarre accounts of their disappearance (e.g. being beamed into outer-space) is unclear. Ratcliffe acknowledges that an additional factor is required, so posits a role for personality traits that pre-morbidly would have been considered normal. When these as yet unspecified traits combine with the loss of affective familiarity the Capgras delusion results. So, to understand the content one must consider the sufferer's pre-morbid personality in conjunction with their experience of affective unfamiliarity.

A COGNITIVE NEUROPSYCHIATRIC MODEL

The phenomenological approach to the Capgras delusion has commonalities with the leading cognitive neuropsychiatric account. Rather than a general loss of affective familiarity however, a modality specific loss of emotional recognition in the visual pathway has been proposed. Maher[14] and, developing upon Ellis & Young's work,[15] Coltheart[16] have argued separately that an "anomalous" experience alone is sufficient to account for the delusion's

content. For Maher, those suffering delusion explicitly reason from the abnormal experience to the specific content, the latter explaining the former. The delusion becomes quite understandable once the anomalous experience is granted. Meaning – and rationality – is preserved. Coltheart, on the other hand, considers that both the anomaly and reasoning lie outside conscious awareness. "What's conscious is only the outcome that this chain of processes generated: the conscious belief, 'This person isn't my wife.'"[17] This implies that, despite the delusional content being an explanation for the anomalous experience, the delusion enters awareness *de novo* out of nowhere. It appears unsupported by other beliefs and thoughts so interpreters struggle to understand why it has arisen. Likewise, the sufferer will be at a loss to explain its origin, given it arose beyond his ken. Why does the patient not then reject such an implausible belief? A further impairment is posited. The Capgras subjects depart from rationality by rejecting evidence such as the testimony of others and sensory information inconsistent with the delusion:

> Despite its seeming reliability, they irrationally ignore or discount the evidence on the basis of its incompatibility with the hypothesis to which they have become committed; so the delusional belief persists… The second factor is a failure of the system whose job it is to consider new evidence… so as to revise current beliefs.[18]

It is unclear whether Coltheart *et al* consider that rationality and meaning are bound as some suggest[19] – Davidson and Dennett included – hence whether the posited irrationality undermines sense. Nevertheless, the manner in which the belief arises and its inconsistency with other sensory information and beliefs implies that delusions, in Coltheart's framework, are beyond an observer's understanding.

CAMPBELL'S RATIONALIST MODEL

Campbell[20] has criticised such "bottom-up" approaches to delusion generally, utilising the Capgras delusion to illustrate his position. Instead, he argues that the delusion may reflect pathology-induced change in the hinge-propositions discussed by Wittgenstein in OC. Thus, what was once held certain is now open to doubt and *vice versa*. He holds that the Capgras delusion cannot be summarised: "That woman over there is not my wife." Strictly speaking,

this implies "that woman" is not in the legal relation of wife, i.e. the wedding was a sham. Given what is at stake – the continued presence of an individual with whom the sufferer has shared much history – the delusion is bettered characterised: "That [currently perceived] woman is not that [remembered] woman."[21] Judging "that woman" to be different from his remembered wife would result in a lack of affective response when she comes in view, so the perceptual abnormality is an effect rather than cause of the delusion. The ideal way to check whether "that woman" is the remembered woman would be to discuss shared experiences. As the patient does not proceed in this manner, Campbell concludes, he has "lost his grip on the meaning of the word."[22] Campbell finds no reason to suppose that organic change or dysfunction cannot change localised "hinges," with repercussions over the entire belief network. Richard Gipps has pursued this line of enquiry and considers Campbell's approach advantageous for a number of reasons, not least of which is the seeming *otherness* of patients with delusions.

> What makes compelling the idea of delusions as altered frame-work beliefs is both the certainty with which they are held and their inaccessibility to those (nonpsychotic) persons whose epistemic houses are built on different foundations. The delusional patient lives in 'another world', and their bedrock beliefs are opaque to us simply because they are not our own.[23]

SUMMARY

This brief survey should demonstrate that meaning and meaninglessness feature in widely differing perspectives of the Capgras delusion. Indeed, meaning is a crucial albeit unexamined feature in each theoretical model. It is preserved in psychodynamic accounts through the deployment of unconscious mechanisms while phenomenological and Maher's models do so only by including an unexplained loss of affective familiarity plus unidentified personality traits. Positing unknown and unobserved processes is required to restore meaning to Capgras' delusion. Coltheart's invoking of irrationality avoids addressing meaning directly but goes some way to accounting for the peculiarity of the delusional belief. It remains an open question whether meaning and rationality are tethered, but the inconsistency with other beliefs and *de novo* emergence claimed by Coltheart pits his model against the psychodynamic and phenomenological ones. Coltheart's model however

includes a hypothesised dysfunctional checking system in place of the psychodynamic and phenomenological desiderata. Campbell's rationalist approach differs fundamentally for there becomes a gulf between all communication; everything the patient says has been transformed so mutual understanding becomes an impossibility. Once again, a hypothesised mechanism is required to explain how a hinge-belief and surrounding structures can be so disturbed. The impression left after surveying the competing models is that while meaningfulness is implicated centrally it functions like an organising principle. The theorists seem to take a view on meaningfulness then build hypotheticals around it. Meaningfulness itself remains unexamined.

VISUAL HALLUCINATIONS

> A person is said to labour under a hallucination, *or to be a visionary*, who has a thorough conviction of the perception of a sensation, when no external object, suited to excite this sensation, has impressed the senses.[24]

Hallucinations in the visual modality appear unproblematic to psychiatry for they are held to denote organic disease.[25] Classed as either "simple" – flashes, geometric patterns, coloured patches – or "complex" – involving figures, animals, and extended landscapes – they are uncommon in the "functional" disorders. Hence, their relative neglect in the psychiatric literature. It is predominantly neurologists who have considered the causes of visual hallucinations. As the late Oliver Sacks described:

> There seems to be a mechanism in the brain that generates or facilitates hallucination – a primary physiological mechanism, related to local irritation, "release," neurotransmitter disturbance, or whatever – with little reference to the individual's life circumstances, character, emotions, beliefs, or state of mind… [patients] almost uniformly emphasise their meaninglessness.[26]

This meaninglessness is, however, surprising. Prior to Esquirol's introduction of the term "hallucination," visions were understood to be portentous, symbolic, and revelatory. That

author relabelled mystics as "only hallucinated" and located the cause within the brain but meaning was not entirely revoked.

> Hallucinations relate usually to the occupations, whether mental or physical, to which the person suffering from them has been accustomed, or else they ally themselves to the nature of the cause that has kindled up the excitement of the brain.[27]

Furthermore, philosophers beware, certain proclivities increase the risk of hallucinating.

> Individuals who, before their illness were controlled by a passion, or subject to strong conflicts of mind, are more exposed to it than others, especially if they have previously applied themselves to speculative and abstract studies.[28]

German Berrios[29] has judged August Tamburini the culprit who stripped meaning from hallucinations. The latter propounded localised irritation of sensory cortex to be the cause of hallucinations, the site determining their modality. The hallucinatory content was regarded an entirely contingent triggering of "mnemonic images, stored impressions."[30] Nevertheless, sophisticated clinicians have refused to imbibe whole the neurologicisation of visual hallucinations whilst acknowledging their status as cardinal features of cerebral disorder. Alwyn Lishman averred:

> They are derived partly from failure to distinguish inner images from outer percepts, and partly from vivid dreams and hypnagogic phenomena which are carried over into the waking state as consciousness waxes and wanes.[31]

What could be more symbolic and inviting of interpretation than dreams?

PSYCHOLOGICAL MODELS

Freud too likened visual hallucinations to dreams and correspondingly undertook their analysis. Repressed memories or conflicts are transformed into externalised images that simultaneously conceal and reveal their unconscious origins.[32] Thus, Paul Schreber's hallucinated heavenly rays were interpreted as a concrete representation of repressed libidinal impulses towards his father, represented as God.[33] If this is correct, then the meaninglessness noted by Sacks is a consequence of repression, only deepening their significance.

> [T]he dreamer does know what his dream means; only he does not know that he knows it and for that reason thinks he does not know it.[34]

Today, few agree with Freud's analysis, but the question of psychological meaning endures. For example, hallucinating recently deceased relatives is common, particularly in the distressed, lonely and isolated, and they are almost uniformly comforting,[35] suggesting a wish-fulfilling or functional role. The preponderance of hallucinated faces, people, and animals over inanimate objects is said to meet "unconscious affiliative impulses."[36] Alternatively, hallucinations in bereavement may be atypical as those considered pathological are distorted in size, occupy odd spatial locations, and jar with the setting.[37] The hallucinated content can be either mundane – a man sitting in a chair – or fantastical – gargoyle faces, a brightly coloured circus troupe,[38] extended vivid landscapes bustling with people and objects.[39] Images can be static, rove within the visual field, or move dynamically. Although where there is movement no narrative unfolds,[40] in contrast to dreams. Psychologically significant hallucinations, such as those in bereavement, may therefore represent a subset while the "complex" variety indicates cerebral dysfunction.

A NEUROPSYCHIATRIC MODEL

Collerton *et al's* influential Perception and Attention Deficit (PAD) model[41] seeks to bring the various visual hallucinatory phenomena under one explanatory framework: "the content and character of [complex visual hallucinations] primarily reflects the nature of visual

processing." The authors "stress the interaction of multiple processes within scene perception rather than the activation or release of specific visual areas."[42] Top-down expectations of the setting create a visualised object in the scene from an anticipated "proto-object." This explains the vivid clarity with which hallucinations are experienced even in those with poor vision. As eyes and mouths attract our gaze more than other facial features these become gargoyle-like exaggerated in the hallucinated visage. Hallucinations often appear smaller or larger than veridical perceptions as the proto-object is projected on to rather than integrated in to the scene. (Compare with Freud's claim that *Emmy von N.'s* visions of a giant mouse related to a frightening play she had been forced to see as a child.[43]) In the numerous criticisms that followed presentation of the PAD model, none sought to re-establish meaningfulness. This despite the obvious question: if the hallucination is generated through top-down expectation, then is not the sub-conscious selection of one proto-object over another of significance? Berrios has bemoaned the "loss of semantic pregnancy"[44] in the study of visual hallucinations; rather ironically given his own declaration that delusions are but "empty speech acts."[45] Nevertheless, one can agree that the contemporary neurological and psychiatric perspectives are largely blind to content and meaning in visual hallucinations.

VISUAL HALLUCINATIONS IN PHILOSOPHY OF PSYCHIATRY

Descartes famously worried in the first meditation that reality is but a false vision[46] and the argument from hallucination is used to support sense-data theories of perception and epistemology.[47] However, in contrast to the reams printed on the Capgras delusion, visual hallucinations are largely ignored in the philosophy of psychiatry. They are omitted entirely from the recent voluminous *Oxford Handbook*[48] and are mentioned only once in passing as indicative of organic mental disorder in the *Oxford Textbook of Philosophy and Psychiatry*.[49] While the meaningfulness of visual hallucinations is un-contentious this denotes elusion rather than successful elucidation.

SUMMARY

There are bipolar perspectives on the meaning of visual hallucinations. Psychoanalytic writers compare them to dreams thus the content is similarly over-determined and

amenable to interpretation. The true meaning of the hallucination is not at first obvious and only comes to be known through analysis and knowledge of the structure of the unconscious mind and its processes. The neurological perspective takes this apparent meaninglessness as evidence for the biological and contingent nature of the hallucinated content. The meaningfulness or otherwise of the symptom is a founding assumption on which differing theories are built.

CONFABULATION

Serge Korsakoff described a 37-year-old Russian writer with a fondness for Brandy-fuelled Siberian sojourns who suddenly developed a profound amnesia. This was associated with the tendency to produce "fictitious stories," such as his claim that someone had attempted to poison him with lead dissolved in vinegar: "In other words, he started to confabulate."[50] The word confabulation has roots in the Latin prefix *con* and stem *fabulari*, giving the literal meaning, "to talk with," irrespective of the truth-value of what is said.[51] The word arose in the vernacular before *Konfabulation* acquired its technical meaning in early 20th Century German psychiatry. The psychiatric use retains the folk's notion of story-telling but stipulates they be "false narratives."[52]

There is no consensus on the definition of confabulation, or even agreement as to its scope.[53] The orthodoxy is they are (i) false (ii) reports about (iii) memory. However, following Norman Geschwind,[54] a broader view has emerged that confabulations are erroneous claims made about any aspect of knowledge, not restricted to memory (e.g. perceptual knowledge in Anton's syndrome.) Advocates of the broader conception prize the parsimony of accounting for various clinical phenomena previously thought unrelated. Thus, anosognosia, misidentification syndromes (including the Capgras delusion), verbal reports of right hemisphere initiated acts in split-brain patients, and self-deception are each explained in terms of deficient knowledge and faulty monitoring systems in the brain.[55] Confabulations of differing types have been described. It is claimed that all healthy individuals have the potential to confabulate responses when they cannot know the answer. Nisbett & Wilson reported numerous experiments demonstrating that subjects provide erroneous justifications for their behaviour,[56] and even the apparently vivid and detailed recollection of

dramatic events has been shown to be highly inaccurate.[57] Pathological confabulations have traditionally been described as "momentary" or "fantastical"[58] and, subsequently, Kopelman reintroduced the distinction between "provoked" and "spontaneous" confabulations.[59] The former is a relatively common occurrence in amnestic patients whereby a gap in memory is filled-in, perhaps "out of embarrassment."[60] The latter are far less common and considered a more severe and distinct phenomenon. They have also been found to involve episodic content to a far greater extent than the provoked sort, which are restricted to personal semantic material occasioned by direct questioning.[61] It is spontaneous confabulations about episodic memory that are the focus of the current investigation. A variety of models have been proposed to explain the presence and features of these confabulations. Kopelman[62] divided neuropsychological models into those that involve impaired retrieval of information versus those postulating defective context and source monitoring. Additionally, recent theories revive the motivational and emotional factors for confabulatory content that have allegedly been sidelined.[63] We will briefly review a leading model from each of the three broad types.

DEFICIT IN STRATEGIC RETRIEVAL

A recurring theme in explanatory models is the notion of faulty memory retrieval processes. The theories differ in their details, but all involve failings of executive function, such as initiating, planning, monitoring, and inhibiting memory searches. Gilboa & Moscovitch[64] base their theory of confabulation on an empirically grounded neuropsychological model of normal memory function. Memory traces are laid down by the hippocampus and related structures randomly, without reference to chronology: traces have no past, present, or future. Recall occurs either as a cue-dependent activation of the memory trace or through orchestrated retrieval. The dorsolateral prefrontal cortex (DLPF) sets the goals for the search while ventrolateral prefrontal cortex specifies the cues required to elicit the memory trace. The ventromedial cortex then endorses or rejects the activated trace depending on a subjective "feeling of rightness."

The model explains spontaneous confabulations as the consequence of a variety of memory retrieval deficits, any of which is sufficient to cause confabulation: i) faulty cue-dependent memory traces; ii) formulation of an ineffective search strategy; iii) defective monitoring of

identified memory traces. The faulty cue-dependent retrieval can activate perseverated memories and recently activated memories. Or, cues from the immediate environment can trigger a memory trace inappropriate to the search goals, which may account for the apparent suggestibility of people who confabulate.[65] Inadequate specification of cues – unduly influenced by environmental factors, wishful thinking, familiarity, temporal confusion, or perseveration – causes activation of incongruous or irrelevant memories. Gilboa *et al*[66] now consider defective monitoring of retrieved memories the prime factor in confabulations. Post-retrieval monitoring has three components. The first is a pre-retrieval "feeling of knowing" about which little is understood. The second crucial stage is the intuitive and immediate "feeling of rightness" (FOR) mentioned above. FOR is influenced by the strength of the memory representation, and as memories concerning the self are particularly salient, autobiographical information evokes powerful "feelings of rightness." Consequently, a false or inappropriate memory is endorsed with a high degree of confidence. The third component is a conscious monitoring of memories for lack of internal consistency, conflict detection, and compatibility with search requirements.

Strategic retrieval models of confabulation, despite incorporating idiographic aspects (autobiography, wish-fulfilment, etc.), essentially disvalue the actual content. Kopelman observed that Luria described confabulations as "spontaneous 'outpourings' of irrelevant associations"; himself considering them "extremely incoherent and context-free retrieval of memories and associations."[67] Thus, confabulations are rendered meaningless for their inappropriateness and/or internal incoherence.

CONTEXT AND SOURCE MONITORING DEFICITS

Dalla Barba[68, 69] has questioned the coherence of strategic retrieval models in a manner reminiscent of Wittgenstein in the *Philosophical Investigations* (§§139-141; 281-284). As the selection and evaluation of memories in such models is an unconscious process, there is the risk of infinite regress. For an unconscious mechanism to discriminate between appropriate and inaccurate recollections, it must be able to represent these memories to itself *as* true or false. But this presupposes the very process the mechanism is supposed to explain, unless another separate mechanism of representation exists. However, this mechanism faces the same troubles, hence the regress.

Dalla Barba proposes the Memory, Consciousness, and Temporality Theory[70] (MCTT), a variant of context and source monitoring deficit models. These conceive confabulations as the faulty temporal ordering of memories, the content, therefore, consisting of inappropriately combined and conjoined memory fragments. Entirely false narratives are created from licit memories. The problem is not impaired memory as such but rather a disordered "temporal consciousness," which contrasts with "knowing consciousness." The latter is similar to semantic memory in that it is the mode of consciousness directed towards objects in their atemporal "multiplicity." Knowledge of cats does not necessitate thinking about an individual cat on any one particular occasion. Temporal consciousness, on the other hand, is knowledge of the object's place in time, thereby enabling the subject to experience herself as continuous. It is absent, apparently, in the severely amnestic who live in a perpetual present, such as Clive Wearing, whose notebooks' abound with entries such as, "I'm awake now… *now* I'm totally awake."[71] According to Dalla Barba, in confabulation the temporal consciousness is dysfunctional. Less stable memories are no longer available to the temporal consciousness, so overlearned recollections concerning the subject's habits and routines intrude as if they were a specific event in time. Confabulations are identified:

> In that they are totally at variance with what the listener expects as an answer, so much so that they push him to consider the patient's answers as not normal, namely as confabulatory.[72]

The answer confounds expectations because it conflicts with background knowledge of the patient. It is out of context. However, the confabulation may nevertheless be semantically appropriate. So, the confabulated response "I'm just back from visiting my mother in hospital," while perfectly comprehensible is incompatible with being a bedbound 86-year-old. Dalla Barba wants to distinguish these "semantically appropriate" confabulations from "semantically anomalous" ones.[73] This latter "carries meanings which are inconsistent with knowledge and information shared by members of society."[74] Nevertheless, both types are similarly composed of autobiographical fragments. He considers the appropriate/anomalous distinction to have greater validity than the momentary/fantastical and provoked/spontaneous dichotomies. For Dalla Barba, anomalous semantic content indicates impaired semantic memory in addition to the episodic memory deficits found in

confabulation generally. Therefore, we can see that meaning plays a dual role in the MCTT. Firstly, confabulations are identified as statements whose meaning is inappropriate to context and secondly, semantic anomaly signifies a more severe and pervasive impairment of memory.

MOTIVATIONAL THEORIES

Neuropsychological deficit models have been criticised on account of their silence about the actual content of confabulations.[75] Why is *this* being said *now*? Conway & Tacchi have observed the frequency with which neurocognitive deficit accounts describe the verbal output of confabulators as "purposeless," "incidental and unmotivated," and "unintentionally incongruous."[76] Basically, content is considered mere accident, hence uninteresting to clinicians and researchers. Others, however, while accepting a role for cognitive deficit, stress the relevance of motivational factors and pre-morbid personality. This perspective has been most rigorously stated and studied by the psychoanalytically-inclined neuropsychologist Aikaterini Fotopoulou.[77, 78, 79] Motivational accounts seek to address various features unaccounted for by neuropsychological deficit alone. For instance, patients who confabulate are visibly less irritable and anxious while doing so;[80] content is often grandiose and enhancing of one's self-image;[81] and the stories frequently appear wish-fulfilling[82] or redemptive.[83] Fotopoulou and colleagues suggest that confabulations convey an overly positive perspective to bolster self-esteem and defend against depression, although at the expense of realism.[84] Imperfect memory and selective recall are understood to be involved in the construction of self-narratives in non-confabulators. In the confabulating patient, impaired processes governing retrieval enhance the role of emotional and motivational factors in recall. A pre-existing self-serving bias is thus exaggerated.

> Moreover, the particular combination of preserved and impaired memory processes will determine the exact form and content of confabulatory memories.[85]

This, however, seems overstated. Firstly, the degree of content explained is restricted to the emotional valence of confabulatory statements not their specific content. The model is silent on why some confabulated content is implausible. Indeed, the claim that all confabulations

are meaningful is belied by the acknowledgement of "incoherent or obscure confabulatory statements." [86] Secondly, although the emotional valence of confabulations is more frequently positive than the pseudo-confabulations elicited from healthy controls, the latter replicated the frequency of positive and negative statements they were shown as illustrations. This may have framed the controls' own creations producing a spurious differential performance. Nevertheless, Fotopoulou's work is a welcome re-engagement with content that recognises the accomplishments of orthodox neuropsychology.

SUMMARY

The diversity of confabulated claims and association with memory (albeit false memories) invites the reading of some personal significance, or meaning, into the specific content. While acknowledging autobiographical elements, the standard neuropsychological deficit models hold these as being too incongruent with the circumstance and internally inconsistent to be taken as meaningful statements. The motivational theory on the other hand cedes a role to impaired retrieval while refusing to accept that content is mere accident. This is more a matter of emphasis than of essence. But still, the deficit theories seek to explain how apparently meaningless claims come to be whereas the motivational theory attempts to show this meaninglessness is more apparent than real. Once again, meaning is an organising principle in the models without ever being tested directly.

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RESULTS: PART A

As per the methodology described previously, Appendix F shows a section of annotated IPA for the first case, moving from the first step of initial coding, through descriptive comments and phenomenological coding and finishing with identification of emergent themes. Themes are narrated for each interview in turn. Quotations are referenced to the appropriate page number in the Appendix. Punctuation of quotes has been kept to a minimum to avoid imposing an external structure or sense.

The first case (Dave) is a man suffering a Capgras delusion and his wife's (Jane) attempts to understand his experiences. The second case (Liz) involves vivid and strange visual hallucinations. Unfortunately, there was no carer to interview in this case but her attempts to understand her experiences warrant analysis of itself. The final case comprises interviews with a confabulating elderly man (John) and his sister (Cath), who is struggling to cope. As already explained, secondary analyses will be presented in *Results: Part B*.

CASE 1: CAPGRAS' DELUSION

DAVE

Dave is a 71-year-old retired painter and decorator diagnosed to be in the early stages of Lewy Body Dementia. Six months prior to the interview he began to believe that an imposter had replaced his wife Jane. Distressed, he repeatedly asked after Jane's whereabouts and rejected assurances that contradicted his belief. This is a second marriage for Dave. The first ended in his early thirties as a consequence of her infidelity. He has been in a relationship with his current wife for ten years, married for the past four. The Capgras delusion worsened markedly after the death of Dave's brother. He would talk to Jane as if she was his late brother, and she in turn was reluctant to remind him of his brother's death for fear of upsetting him unduly. The following themes emerged in the interview with Dave about his understanding of the Capgras delusion. The full interview can be found in Appendix G.

BEING TOWARDS DEATH

It is striking that the interview begins and ends on the theme of mortality. Such bookending indicates the centrality of death in his thinking, though it is absent while discussing the actual Capgras delusion. Hence, death may be an important theme yet unrelated to the delusional content. Dave's opening remark of the interview is revealing: "*for 'er it's an illness a funny illness, well not funny but frightening, has passed a lot of stuff through my mind of what is going to happen, how it is going to happen and hopefully in the end it might be a better, for the want of a better word, finish*" (216)

"Being toward death" is an avowedly Heideggerian term that captures Dave's situation. Death imposes a limit on existence that enforces decisions about identity. Dave is now reflecting upon his life, what he has made of himself, his sense of having been a failure, and the quality of his relationships. His identity appears in a state of some flux. One of the last comments of the interview connects his father's death with deliberations on the life he has lived. "*[I] was bound for the good stuff, but it never happened…. I didn't ask my dad to die when I was 10-and-a-half, I don't know, maybe I am just one of those guys, you know it's not for you but you get on and do your very best in the world and get on from there.*" (229) There is an undeniable sense of regret but also affirmation of having partaken in the struggle to make sense of life. However, the dementia appears to be setting limits on his possible existence just as death must. Dave seems to be not just contemplating death but also has a sense of dementia *as* death.

IDENTITY IN CONFLICT

Dave frequently compares himself unfavourably with his past identity and, especially, his pre-morbid capacities. He speaks of having possessed a "sharp" mind: being able to remember songs and poems. Such assertions of vitality and intellectual capability serve to bolster a positive self-image yet simultaneously undermine given the contrast with his current condition. "*When I was like that and they said, 'So what do you think about that?' it was bap-bap-bap-bap and I couldn't go wrong at all.*" (216) It appears these deliberations on decrepitude conflict with a more sanguine attitude towards himself. When discussing the feedback he has received on the "*tests*" completed during cognitive examination he described himself in favourable terms: "*I didn't um [laughs] taking it in and thinking there is*

nothing wrong with my head, it's alright, I've got a great head and that I know that for sure." (221) There is thus some ambiguity about the diagnosis and its impact upon Dave's identity. Assertions of scholarly aptitude in childhood confirm its importance to his self-identity. But just as his potential was foreclosed by his father's death, dementia repeats this once more.

OVERPOWERED AND OVERWHELMED

Events beyond Dave's control shape and dictate his life. He often feels powerless in the face of such events, which can be external to him or internal, such as overwhelming emotions. The dementia is personalised and externalised as a "*bad man*" (228) he must resist, although he is uncertain whether he is capable. "*[I]t won't let me do anything, it is crushing me and it was awful and it still is awful, I can't stand the bloody thing*." (217) "*I am so afraid that I am not going to be good enough, strong enough to stand up to them [the dementia]*." (228) Similarly, his experience of emotion is described as overwhelming and unmanageable. In particular the prospect of abandonment is unconscionable. "*I just don't know, it was a terrible, terrible, terrible experience, I mean really bad because it made me cry and it made me, I wanted Mary, I wanted her with me. I couldn't bear the thought of her not being there or if she just turned on her heels and walked away from me and all that sort of stuff.*" (219)

REJECTED AND ABANDONED

As details of the Capgras delusion were explored, themes of rejection and abandonment came to the fore. Dave drew parallels between his present fear of abandonment and his ex-wife's infidelity. That others knew of her cuckoldry before him nurtures his suspicions about Jane. The overwhelming anxiety and anger alongside the wandering search for his "real" wife is reminiscent of toddlers' ambivalent attachment behaviour. "*So the others I was just meeting them, they would go away and I would go and look for Jane and Jane wasn't there… and I would start to boil a bit and start to a panic.*" (219) "*[N]ow Jane, is just is Jane there and that is all I wanted, nothing else*." (225)

Dave worries that his wife finds him boring, a burden, and suspects her of eloping with another man. These fears bear striking similarity with his explanation for why his ex-wife left him: "*I wasn't a very go-get guy*." (221) "*[She] liked what she was doing, having a few drinks,*

laughing with the girls and all that sort of stuff and then one lonely cowboy and it's a panic then for him and it is awful." (227) Thus, aspects of the Capgras delusion and his understanding of his ex-wife's actual leaving correspond. This however neither explains the reduplication nor why he finds their presence so distressing. Dave might be ambivalent about his marriage, wanting Jane to leave him due to his illness and loss of vitality yet having an increased need for her, exactly for those reasons.

DISAVOWAL OF ILLNESS

Dave intermittently acknowledges his illness, although he talks primarily of a memory problem rather than dementia. He frequently deprecates medical explanations, information leaflets, and the consequences of illness. At most he sees the medical explanation as one model among others equally plausible, but he considers it irrelevant to the content of the Capgras delusion and alienating. When he does endorse an illness attribution it is on the basis of medical authority only and not for any reason with which he concurs. "*Even when someone says to me, 'Well it's a sickness,' you know once I heard that I had it, it's a sickness, and it's an illness. I thought it's not an illness for God's sake. An illness is when something they give you makes you alright but it's all mixed up together, the memory thing I would sooner go for that than the dementia thing*." (223) "*Well it wouldn't always be in illness, would it?... I don't think there is anything else, is there. I mean you were saying that is what doctors and what they think… [W]ell yes it backs up whatever it is and whatever the others are thinking, whether you are thinking that or not.*" (227)

Of psycho-educational literature: "*[I]n a case like this, when you start reading it and you develop a piece of it again and again you start to think: Oh yes, oh yes, you do um you do think um… that is what you do and plus you carry on with anything else you can get your hands on [laughs]… I liked reading it and then having to read it again to understand what I am reading about*" (227-8) Dave seems reluctant to accept he is unwell since that implies his beliefs about Jane disappearing are incorrect. Reciprocally, if he accepts he is wrong about his wife then he must accept he is unwell. There is a sense in which, if he is wrong about his wife then things are far worse for him than he can suspect. The motivation for him to minimise illness and the possibility of error in his beliefs is powerful. What is more, the one demands the other. "*Well what else can you do, what else can you think, you either believe*

what you are seeing or what you are being told…" (228) All this accords with Dave's struggle for identity and purpose: "*I really don't know, all I know is that particular part of me, I know how I am head-wise is not letting the bad man win, I want to win*." (228)

JANE

Jane, 56, lives with Dave who suffers with the Capgras delusion. He accuses Jane of being an imposter and says his real wife is missing. Jane is committed to caring for Dave but finds his claims distressing and perplexing. Presented below are the most significant themes identified through IPA. The full interview is in Appendix H.

IRRATIONALITY

The most frequent theme raised by Jane related to difficulties with Dave's reasoning: "*When I say some of it is hard to understand it is more about where he would get the logic of thinking what he is saying*" (236) Jane's repeated quoting of Dave serves a number of functions. For one, it demonstrates her excellent recall of events, superior perhaps to Dave's. This demonstrates that she listens to Dave while also holding him to account for his words – they cannot later be denied. Implicit in the use of quotes is that others will concur with her evaluation of them as erroneous, ill-grounded, and irrational. The irrationality is obvious to all except Dave who is both included and excluded by the quotations. "*I would say 'if I wasn't here how would I know all this?' and he would say 'you are a witch, yous (sic) are all witches and that is how you tell each other, and you're going to tell her now and when she comes tomorrow she will tell me everything that happened because she will say that she's been there, but she wasn't there.'*" (236)

Supporting her view of Dave as irrational are occasional references to animal-like and childlike states: quintessentially exclusive of full rationality. She says Dave "*is like a dog with a bone*." (237) Contextually this refers to his tenaciously asking after Jane's whereabouts, with unreason as implicit subtext. Dave is initially presented rather ambiguously as "*top in the class*" (228), connoting a boyish intellectualism. A childlike state is again alluded to near the interview's end: "*As long as you are happy with me and you're safe and you're washed*

and you're looked after and whatever, it doesn't really matter who you think I am." (244) This could be a portrait of decrepitude yet is strikingly similar to childcare.

INTACT REASON

Preservation of reason and rationality also frequently arose in Jane's interview. For instance, she interprets him reasonable in light of his beliefs: "*I think he is saying 'I don't believe these people, they couldn't have got out the front because I have been standing in the hall' sort of thing*." (235) The difficulty arises in understanding the underlying beliefs. "*Even though I have done my best to convince him that they don't actually exist to him they do, but that is fair enough, though therefore, as he says, if they are in the house they must have keys*." (238) At other times Jane reasons with him hoping to persuade him of his error: "*I try to think and say, 'Ask me something nobody will know but me.' Anything you know, I would say to him 'Look at my tattoo' and he will say 'You all have it.'*"(236) But the basis for the delusion is difficult to "grasp."

Having criticised some of his utterances as "*gobbledegook*," (234) Jane expands: "*Well we are not talking about, well, we haven't watched something on the TV where there was a woman in it and there was a giraffe in it, you know, you look out whether it is the plants or something he seems to see*." (235) She clearly looks for explanations for his beliefs and attempts interpretations preserving of rationality. This can lead to difficulties: "*Because he says, 'I don't understand how you couldn't have seen them' and he says 'I am distressed now and you are a member of my family and I am asking you and you won't answer the question'… and I think it's hard to really know what to do.*" (234) At such times it is not clear to her what answer could satisfy Dave.

THERE IS NO INTERPRETATION

At points, Jane uses words – "*twaddle*" (231), "*gibberish*" (p. 230), "*gobbledygook*" (234) – that exceed deprecation. They imply nonsense, meaninglessness, and unintelligibility. Dave's utterances no longer have the import and weight of true communication: "*My understanding is it is just what is going on in his head*." (237) "*I think that he is just sort of talking out loud, so he is not actually…*" (239) At such points communication has ceased and

she no longer attempts to engage him. She distracts him with another topic, leaves the room, or listens passively. Nonetheless, there is something more fundamental than words that she has to offer: care.

CARE

Echoing the subtheme of childishness, this theme arose at both beginning and end of the interview. Jane's description of Dave escaping from hospital to home and the aftermath illustrates salient facts. Firstly, he returned home to her. Secondly, she knew more than the nursing staff and, significantly, his daughter. Jane thereby demonstrates that in spite of his denials he acknowledges her as his wife by his actions and, furthermore, she provides superior care to him than others are able. The caring relationship is unaltered despite the illness and everything that Dave *merely* says. Indeed, it is this that explains her being the focus of Dave's delusion. "*I don't know if he is thinking it is impossible for anyone to be with someone 24 hours a day. I don't know as I said, are these extra Janes a little net for Dave? So he goes, 'Well if you decide to say "OK I have had enough, I can't do this I'm going,"' well he goes 'OK, well I have got the other Janes, it won't be a problem, I can do this.'*" (243)

Before moving on it is worth reflecting on the emergence of the themes discussed thus far. The themes of rationality, unreason, and un-interpretability bunch together in the text and Jane seems not to have come to a stable conclusion but is struggling with them in her daily experiences with Dave. She seeks to interpret wherever she can but is at times unsuccessful. While disengaging from conversation Jane does not cease to treat him as her husband. She continues to act. Jane cares and comforts Dave in the face of and despite his many protestations.

REJECTION

A recurrent theme is Dave's fear of rejection. She interprets his claim that the real Jane is absent as signifying an insatiable need. "*He is always looking for me…. He used to just follow me around saying 'Where have they gone?'*" (233-4) Jane states that he has always been insecure in their relationship, so interprets the multiple imposters as a security-net – should one abandon him, others will remain to care for him. This theme implies a psychodynamic

process, since the underlying state – "I fear abandonment" – is not fully available to Dave. Despite this, she is not always convinced of the interpretation and her centrality is not always reassuring: "*It really bugged me in the beginning, as I said to him… 'I don't understand it because you know who everybody is, every neighbour in this block you go "Hello John, Hello Charlie" or whatever. What is it with me?'*" (242)

PATHOLOGY

In parallel with her interpretative endeavours Jane also suggested Dave's problems arise due to his dementia. She repeatedly discussed medical issues and how receiving the diagnosis had been helpful. However, it is a queer sort of help that offers little of obvious substance: "*It was nice for someone to actually say well you know what it is and you can thank God at last*." (244) The diagnosis helped her to formulate an understanding that encompasses biological elements and Dave's premorbid characteristics. She twice described the problems as arising not from faulty memory *per se*, but as a consequence of impaired access to intact "*information*." (243) Hence, everything he says is relevant but its expression disjointed; so Jane is muddled with his faithless ex-wife.

A subtheme of drunkenness also emerged. Jane viewed inebriation as analogous with Dave's present state and, reciprocally, past drunkenness became intelligible in the light of the dementia diagnosis. Drunkenness conveys a surfeit of symbolism; it is no coincidence that Dionysius is the God of both wine and madness. Alcohol has undeniable biological effects yet the drunk is not rendered entirely senseless. There are associations with aggression and unpredictability. While less responsible for what he says and does, hidden truths are nevertheless disclosed: *in vino veritas*. Alcoholism is both a disease and moral affliction.

CASE 2: VISUAL HALLUCINATIONS

LIZ

Liz is a pleasant South Londoner in her mid-seventies. She is down-to-earth and speaks matter-of-factly but expressively about her unusual experiences, as the interview in

Appendix I demonstrates. Following a severe heart attack and right parietal stroke she spent time on the Intensive Care Unit (ICU). Afterwards, she began to experience visual hallucinations, with occasional auditory components. Upon regaining consciousness she saw a vivid and detailed scene of Victorian buildings, an injured child lying in the street, then a large black door opened to reveal an elderly woman with a large cat in a room filled with red furniture. Since discharge she has been seeing plastic flowers dancing, seven-foot "angels," an aged dandy cycling around her bedroom, and tin soldiers materialise as sleep approaches. Liz now sleeps with earplugs, has placed her dolls in a cupboard, avoids her bedroom, checks the house for intruders, and has fled these apparitions, causing her to fall.

Liz had a difficult childhood. The fourth eldest in a sibship of eleven she alone was given up for adoption at five months. Liz has never discovered why, although her siblings have intimated they know the reason. She was raised in a Salvation Army orphanage. She had contact with both parents until their deaths but developed a closer attachment to her father. Liz married but this ended due to his drinking and infidelity. Her ex-husband has since passed away. She twice hallucinated his image prompting a vituperative dismissal. Liz has not seen him again. She was referred to a psychiatrist due to anger and aggression towards others, which has led to her being ostracised. The hallucinations are unresponsive to treatment and their aetiology remains a mystery. Charles-Bonnet syndrome has been proposed but her vision is far better than would be expected. Peduncular hallucinosis is a possibility (although visual material dominates other modalities can be involved[1]) but subsequent to the interview she was diagnosed with a pancreatic tumour and so a paraneoplastic syndrome is possible. The following themes emerged at interview.

UNCERTAINTY

The most striking feature of the interview with Liz is her deep sense of uncertainty. "*I know it can't be true, animals don't talk to you unless they are real, but mine do*." (246) Liz is unsure *why* these experiences have begun and finds the medical explanations, as she understands them, unsatisfactory: "*They just said "your brain is dead, on the left side"… but it is not the full explanation*." (253) However, her uncertainty manifests in her vacillating between the view that she is ill, and acceptance that the perceptions are veridical. "*No it is all in my mind, it has got to be*." (248) But shortly after Liz asks, "*Why are they laughing, I*

don't know. I wish someone would tell me." (249) She seeks explanations but finds them all wanting. This uncertainty undermines her relations with others: her GP, district nurses, family, and friends.

RUPTURED TRUST AND COMMUNICATION

Liz no longer trusts the word of others. Not her GP, not the doctors or their explanations, and not her family. Of doctors Liz wonders, "*I don't know if they are confused or what or hiding something*." (256) She is particularly critical of her GP whom she accuses of being callous: "*If you go down to the doctors' surgery and you are telling him about your life history, what is he going to say? He can't do nothing*." (263) Similarly, she feels disbelieved by her friends and family. "*They say that 'It is all in your head... you are imagining it all,' I say 'I wish I was.'*" (255) Furthermore, she feels belittled and denigrated rather than understood: "*Friends don't understand, they laugh at me… but they laugh at me and say 'Don't talk stupid you haven't got a dead brain'… but it goes through their ear and out the other end, they are not really interested*." (255) This lack of mutual trust has soured relations. Liz has withdrawn from social groups and no longer confides in others. "*No one believes me. It feels nasty; it makes you feel you're a liar*." (259) Only the mental health professionals can be trusted, as they know how to talk with her. But even this is only partial, "*Oh a load of people don't understand, and I suppose you don't even understand*." (261)

MEANING VS. MEANINGLESSNESS

An aspect of the experiences that she struggles with is what they mean. Just as she cannot understand why they are happening – they seem to have no *reason* for being there – she cannot understand why *these* images: "*I don't know, I have been asking myself 'why?'*" (249) "*Why are they laughing? I don't know. I wish someone would tell me*." (249) She cannot recall having seen anything similar and with the exception of her late ex-husband she does not recognise them. So they are not connected to known memories or related to childhood experience. On describing the clothes worn by some hallucinated figures, Liz exclaimed, "*It is like all frills what come out and they come round in a big wide square at the bottom, yeah. Why I have never been to a ball place in my life*." (249-50) So Liz searches for an explanation for the particular hallucinated content but struggles to find any: "*It doesn't make sense.*" (254) However, they are not entirely without signification. She wonders whether they may

be predictive of her death or hauntings. "*Is he [her late-husband] doing this to me? I don't know*." (252)

BEING TOWARDS DEATH

Death is a recurring leitmotif in the interview. Liz believes that she was brought back from the dead, part of her brain is dead, the seven-foot woman is an angel signifying her death, and some of the people seen are dead. She takes the hallucinations as signifying her imminent demise: "*Oh well, it won't be long before I am down there. You know it is just a word you use. I say it a lot*." (250) And again, towards the end of the interview, "*Then it won't be long before I am down there then will it*." (262) Of note, Liz says that her family do not discuss the topic of death preferring to talk about their shared experiences. "*We don't talk about the past people who have died, my family don't. I mean I got ten sisters and one brother and we don't talk about death, we talk about life now*." (260-1)

ALTERED SELF

"*I died and they brought me back but it has left this part of the brain no good, not working that is the cause and ever since then I haven't been* right." (246) Liz is no longer the strong robust person she was: "*I had the brain, er, heart attack*." (251) She feels unable to perform basic chores, she has low self-esteem, and she feels withdrawn and stigmatised. "*I have always been happy-go-lucky, go out with friends and that, now I don't want to do nothing*." (254) "*No, all jokes aside I hate to think I am walking around with half a brain not working*." (257) Her reaction to being disbelieved has been to feel angry and resentful. Liz now fears she could be violent and dangerous. "*I want to hit everybody, I have never been like that in my life. If anybody touches my kids, I swing 'em! And I shouldn't be like that.*" (257)

FEAR OF MADNESS

Liz is constantly in fear that her brain is dead and that she is becoming "mental." "*What's going on up there, but I don't want to be one of these people who go mad, I mean you see a lot of bad people gone mad*." (253-4) She feels stigmatised but likewise stigmatises those with alcoholism with whom she has had some contact, as there is a dry hostel near her flat.

"*Oh they make me laugh [laughs], they are not nasty. You know what I mean? They want to be a friend to you but I wouldn't have them as a friend [laughs] … no don't invite them in 'cos they will send you mad [laughs], but I wouldn't hurt them*." (264-5) She fears contagion and shuns them as her friends shun her. This fear seems to drive her away from companionship so she feels excluded and disdained: "*Don't keep me, um, hidden. I am still a human being*." (256)

CASE 3: CONFABULATIONS

JOHN

John is a retired 76-year-old from Ireland who lived and worked in London for many years. He was abstemious and hard working until the death of his wife shortly after their fourth child was born. Thereafter, John raised the children alone but drank heavily to cope with stress. Seven years ago, he moved into the same sheltered-housing scheme as his sister at which point he regained sobriety. All was well until a few months before his recent hospital admission. John began to spend more time away from the flat and would be found at significant locations, such as the house where he lived with his wife and old workplaces. He appeared disorientated so was returned to his flat by the police. His sister Cath was doubtful of his peregrinations, such as his claim to be the sole survivor of a shipwreck. She questioned his ability to remember recent conversations and requested referral to the local memory clinic. Suddenly he disappeared for 48 hours and was brought to the local Emergency Department by the police. Neuropsychological testing and neuroimaging were in keeping with the early stages of an Alzheimer's type dementia. John was noted to confabulate about his recent past. The following themes emerged in the interview (see Appendix J) with John about his understanding of these confabulations.

THE HONEST MAN

John's repeated assertions of truthfulness are intriguing given some have dubbed confabulations "honest lying."[2] Honesty, for John, is equated with maturity and humanity. Despite their poverty his family prized honesty, which conferred status and dignity. John recalls various family adages concerning this virtue. He reported his sister as saying, "*There is*

no need telling lies when you can tell the truth." (286) John has sustained this family value, "'*Cos my kids I used to tell 'em, 'Tell the truth.'*" (290) At the interview's end John reflected, "*But a man is a man, whatever he may be*," (291) echoing Robert Burns' *A Man's A Man For A' That*.

The honest man, tho' e'er sae poor,
Is king o' men for a' that.[3]

John also considers the assumption of truthfulness: "*I mean what can you do? Um, if someone tells you something you think it's true, or* vice versa." (272) But this assumption is not always granted to John, with grave consequences: "*Oh if you are telling the truth and someone doesn't believe you, I think it is one of the worst… walk away. […] If they don't [believe], you can't do nothing about it. All you can do is state your facts.*" (287) Honesty is a Categorical Imperative for John. To illustrate, he conceives an errant co-worker about whom John would unhesitatingly tell the truth, regardless of the consequences: "*You are going to hurt someone, but it is better that you tell the truth*."(290)

John contrasts his own dependability with the duplicity of others. "*I don't tell lies, I don't have to. Other people can tell them, I go away and laugh because it doesn't bother me*." (272) "*You see I know people who never stop lying, all the time*." (287) The confabulations also portray him as a dupe of other people's lies and deceit: the cleaners who offered him work only to imprison him; the farmer who reneged on an invitation to stay the night. Even policemen are suspect: "*Surely you are not going to give in to him. I wouldn't*." (287)

Nevertheless, John has an inkling he may less reliable than he presents, acknowledging himself a good teller of "*stories*" and that others doubt him: "*I suppose they think I'm making it up. Maybe at times I do. I don't know.*" (284) Even he has trouble accepting some of his claims, "*Sometimes I find it bloody funny myself, you know things happen that you wouldn't think would happen*." (284) Indeed, early in the interview John identifies the problem, "*It is just that I imagine*." (270) John's frequent assertions of honesty counterpoised with his disparagement of others leaves an impression that the "honest

lying"[4] dictum is inadequate, yet he appears unable to discriminate fact from invention. John doubts himself more than his confident assertions initially intimate.

ALONE AND ADRIFT

The abiding sense of John is a man alone and adrift, knowing neither where he has been nor where he is going. He is dislocated in space and time and from his community. A question concerning his recent past exposes a disorientation that he relates to his wife's death: "*Well um I can't remember, well the whole point about it is my sister came down here to work and I came down to um try to find her address, but I didn't, but I got to get her anyway…. I was different places. I only got married once and she died and that's it.*" (269) Speculatively, the dementia renders him equally alone and adrift as the premature loss of his wife.

His erroneous assertions that Cath wishes them to live together communicate a need for safety and comfort. This need is signified by the confabulation in which John claimed to have been discharged from the hospital – see *Denial of Illness* section below – when he happened upon a caring household. "*They were a lovely family… and the lad told me yesterday, um last night, he took me in and he was very nice, 'cos I had no place and I thought to myself God and he gave me breakfast this morning.*" (274) But ultimately it is Cath with whom he wants to live. "*So she says come and live with her, she has got her own place and this, that, and the other, and all I have to do is whatever, and we do get on.*" (276) Furthermore, a leitmotif of the confabulated narratives attributes his predicaments to maltreatment by others: the cleaners promised a job then abandoned him and the farmer was despotic and capricious. The latter deserted John in unfamiliar countryside: "*I wanted to go to London, but I couldn't get to it, so he said he would contact my sister you see, then she would come and take me you see. Crafty, he is a crafty bloke.*" (274) At other times John appears to prefer isolation, stating he should leave people to their own devices. He would, "*Sooner walk away. Honestly I would. I would sooner walk away and my sister even says today, 'You usually walk away.'*" (283) In fact, "*The best thing you can do in an argument is walk away, but it is not easy to do.*" (287) This need to "walk away" is perhaps linked to his troublesome and perilous wanderings. That these take him to significant locations implies that it is his sense of being alone and adrift that causes him to wander. These peregrinations signify John's need to find home.

DENIAL OF ILLNESS

John repeatedly denies being ill while acknowledging that others may, "*Wonder whether that fella is the full shilling.*" (285) Proclaiming rude health he assures, "*My sister doesn't think that I'm sick, maybe they think that I am sick up there, but I am not sick up there neither, 'cos I'm intelligent enough*." (269) He acknowledges his poor memory and recalls undergoing investigation at the local memory clinic. While he initially asserts, "*The doctor said that they found nothing [wrong on the CT head]*" (271) this later gives way to anxious requests for the results. However, this was followed by his minimising any problems that might be found: "*I haven't heard the result. You could find out that? I don't think that there is much wrong, well they might say there is bits, but there is bits in everybody.*" (272-3)

John's denial of illness, as with his assertions of honesty, suggests a paradox. Denial depends on an awareness of what must be denied, so it is simultaneously known and unknown. Humour is deployed in a way that allows John to vent his fear of mental illness and involuntary confinement: "*Is he a doctor an' all? [laughs] He'll lock me up and throw away the key*." (288) This fear that there is something wrong is revealed in John's belief in the omnipotence of the psychiatric gaze: "*I mean the psychiatrist, they will know everything about you and if they printed everything they know about you, then you'll be in prison [laughs]*." (278) This omnipotence contrasts with an apprehension that his own self-awareness is limited: "*But there might be something, there must be, I can't, maybe I can't control it but I don't know about it*." (275)

POSITIVE SELF-IMAGE

Denial of illness and assertions of unequalled honesty present a far rosier picture of John's circumstance than is in fact the case. These positive self-portrayals are buttressed by repeated allusions to himself as an industrious autonomous agent: "*I can do all casual work or something you know in the farms so, um, I can draw me money*." (271) Such assertions are however in diametric opposition to an increasing dependence on others. Similarly, his rejection of authority figures such as the tyrannical farmer sustains this portrait of determined independence: "*He wanted to dictate to me and I said, 'No.'*" (274)

CATH

Cath, a 68-year-old woman, lives in the same sheltered-housing scheme as John. They have been close for many years, but over the past six-months she has become increasingly worried. She feels unable to cope with his wandering and takes a dim view of his drinking alcohol after seven years abstinence. She is both bewildered and bemused by his tales of misadventure but is now adamant he should be placed in an environment that restricts his perambulations. Cath has her own health worries so insists that, despite the care she provides him, she is not seen as John's carer. The interview (in Appendix K) sought to explore Cath understanding of John's stories and pertinent themes are presented below.

UNRESOLVED GRIEF

Cath is convinced that many of John's problems stem from his wife's untimely death. "*She used to work in the hospice, and she was, she was a good woman. I mean if you lose your wife and you have all them kids, you can't be right, to look after a little baby just born. And that is when he started the drink*." (298) The burden of being a single-father with four children to care for was compounded by the death of an infant: "*He lost a little baby too when she, um, for a few months, um, when she was born with pneumonia. He often mentions that.*" (297-8) Cath believes that a visit to his late-wife's grave has reactivated unresolved grief. "*When Bert his son took him to the graveyard to his wife's grave and put a [head] stone on it, it all seemed, he changed completely, he just changed*." (295) She is critical of her nephew for facilitating the visit and worries that John intends to join his wife. "*I think he knows that he is going to go there because that is where he is going to be buried with his wife. So I think that it is all in his mind.*" (295) Unresolved grief is a strong organising principle for Cath. She worries that he no longer cooks and is losing weight. He drank heavily to forget his sorrows, which she believes has resulted in brain injury and moral laxity. Furthermore, it explains his recent wanderings, his retreat from life, and preference for an alternate reality conveyed in his confabulated exploits.

OUT OF TIME

John wanderings are, in Cath's view, a manifestation of his reliving the past: "*He went back to places where he used to be. He went back where he used to live and where he used to*

work… and then he went looking for his kids." (294) In particular, John has reverted to his childhood. Cath insinuates that as John was a miscreant he was compelled to attend a disciplinarian special school. "*I know when he was growing up that he was a problem for my mum, and I know that he was put in a school and he can tell you everything about that, even his mind is not... right for this time, but he knows all about them times.*" (296) There is some degree of agency involved in turning away from the present: "*They know that they are living in that time, they are not living in this time now, they are living in the past*." (295) Likewise, his wandering is seen as the literal and metaphorical rejection of the present: "*He is always running away, why is he running away? Because he had a nice flat, I am there I cook for him, I do whatever I can, but it is not enough somehow.*" (298)

There is, she believes, internal consistency from John's perspective despite appearances: "*Because you can't get inside their mind, inside their brain to know these things. Only they know.*" (298) Living in the past is related to otherworldliness. "*I mean you know people with dementia, they are in their own world you know, they have, they have a world of their own and they can live in that world for a long time you know, dementia people. It doesn't kill them you know, it is just that they could go out and get harmed*." (308) This other world is comforting and the worst of life's trauma's reversed – "*'Cos that world is right, he thinks that world is right for him*." (308) Nevertheless, Cath struggles with the content of confabulations for their discontinuity with his past. She is perplexed by John's claim to have been aboard a sinking ship: "*I just thought, 'How can you say that you were on a ship and the ship sank and everybody has gone but you are still here?'*" (301) Eventually she recalls his being saved from a capsized small boat as a schoolboy. Other confabulations, however, are less readily situated in his life-experiences: "*He told me that somebody died in the hospital and the police were in looking for the people that killed him. Now where did he get that from in the hospital?*" (307)

BRINGING BACK FROM ERROR

Cath is disconcerted by the confabulations because they are, for her, self-evidently false: "*Well I thought: It is not true, you can't think that is true. I could never think that he was on a ship [laughs] and everybody died and he got saved. That would be a miracle.*" (300) Cath disbelieves his claims as assuredly as John is certain of their veracity. "*'Well,' he says, 'I was.'*

But you can't say to him 'You wasn't,' you know." (301) "*He thinks that I am daft [laughs] because I don't believe them.*" (309) Cath scorns the wardens in the housing-scheme who advised against challenging John. "*The warden says, 'You can't, you just have to say, "Yes," say "Alright,"' but I can't, I can't do that. I have to ask him, 'Where is this? Why did this happen?'*" (303) Questioning his anecdotes is, for Cath, an act of care that dignifies his humanity. "*You see, you never know a person, you have to know them deeper than just saying, 'Yes.'*" (303) Cath hopes her inquisitions will prompt John to doubt. He might reflect, "*'Oh, maybe I'm not certain, er, something is not right.'*" (304) Ultimately, emphasising his errors might "*Get him back in this life, um, in this time.*" (303)

ALTERED HABITUS

Cath is concerned by John's altered habitus, those entrenched habits, skills, and dispositions perceptible in everyday actions and behaviour. It was the observation of change here that alerted her to illness before even the confabulations, "*Because I am so used to him I know, I know the way he is... when he is alright he is fine, he is cooking, he is a great cook, he is cooking, he is doing everything, and he looks after himself when he is well. He is not now.*" (296) Cath questions her interpretation of John as "running away" from grief and suffering in the light of his premorbid habitus. "*Did he always run away? He couldn't have 'cos he was married and settled, so he couldn't have always been, he was a worker, he worked, even when he had his kids he paid a woman to look after them to work and go to work, so he wasn't running away then*." (298) Whereas he was previously always laughing, now "*he is very moody, he is moody today*" (299) and his enjoyment of film is described using the past tense: "*He was very interested in films… he loved the old films.*" (300) In an attempt to guide John back to the "real" world, Cath prompts him to restart these old routines. "*Sometimes when he was at home in, um, when he wasn't running away, I would say to him 'Are you going to peel the potatoes now for your dinner?' and he would say 'Alright' and go and do it.*" (305) Such habits are the mark of mental wellbeing, the very opposite of his illness: "*He would lapse you know, he would lapse, and he will forget, and there is another time he would be cleaning and he would have his whole flat all cleaned… because he always used to be good like that.*" (305) For Cath, John's altered habitus is as pronounced and worrisome as the confabulations. It sustains her worry that John is moving towards death.

TOWARDS DEATH

John was gravely ill a few years previously, at which time he confabulated stories about being left at a train station and being imprisoned in the hospital attic. Cath fears that John is willingly approaching death once again. "*He is not worried if he dies, you know he doesn't worry about that.*" (296) His rejection of life is most visible in his refusal to eat the food she provides: "*You see he has no weight on him, he is not eating, I have tried everything, he is not eating now.*" (308)

The theme of being towards death may be a superordinate theme that pervades the others. John's living in another time and place signifies his rejection of this world and preference for another: "*I think they [the demented] are in a nicer place… He doesn't worry, nothing is worrying him anymore… and he is not worried if he dies, he will tell you he is not worried about dying.*" (308) He will in death be united with the "*good*" and "*settled*" woman who was able to "*keep him without the drink*." (298) The nature of his altered habitus that stands out for Cath is his self-neglect: he no longer cooks, cleans, or eats. His wandering is a "*searching for something*" (310) that cannot be found, "*he doesn't want to stay anywhere*." (310) John, Cath fears, rejects the world, preferring death.

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RESULTS: PART B

Part B of the results contains the secondary analyses. Here, the interviews are considered in light of the theories of meaning espoused by our three philosophers. The cases are taken in the same order as they are in the previous section. Each sub-section begins with a brief survey of relevant discussions in the contemporary philosophy of psychiatry literature that apply the philosophers' theories to the neuropsychiatric symptoms under consideration.

CASE 1: DAVE

DENNETT & CAPGRAS' DELUSION

Dennett has recently discussed Capgras' delusion in *Intuition Pumps*[1] and earlier in *Kinds of Minds*: "This amazing phenomenon should send shock waves through philosophy."[2] Despite descriptions of patients decapitating loved ones,[3] Dennett assures us "Capgras sufferers are not insane" but have instead sustained "brain injury." [4] As he advocates the neuropsychological model of the delusion – an explanation at the design level – and describes the content as "imagination stretching," "metaphysically extravagant," and "bizarre," one surmises the delusion is uninterpretable from the intentional stance. Instances of murder do demonstrate people act based on the delusional content, thus showing that action, belief, and desire meaningfully interconnect. However, this may fall under Dennett's "nature of response patterns"[5] that neuro-scientific explanations of mental disorder should provide. The delusion he describes is a circumscribed and "emergent" mistaken belief: "The sufferer has deemed true some very specific propositions of non-identity: 'This man is not my husband.'"[6] As Dennett takes the view that the delusion represents "cognitive pathology,"[7] it follows that Dave should not be understandable or predictable from the intentional stance. However, Dennett's rather neat description and Capgras' original paper bear little comparison; the delusion seen in clinic appears more amorphous than the philosopher supposes.

DOES DAVE BELIEVE AND DESIRE WHAT HE OUGHT?

Dave does not hold all the true beliefs he *ought* about his environment: "*I look at Jane and, um, Jane would disappear…. and then when Jane came back it was just something that wasn't the same*." (217) From an observer's perspective he ought to believe that Jane is his wife but, suddenly and inexplicably, he does not. The failure to hold the belief about his wife's identity that he ought is not restricted to the immediate environment but involves non-perceptual aspects too; claiming someone is an imposter is to know something of his or her personal history. Dave is convinced Jane plans to leave him: "*I was panicking and I was afraid, I was afraid I was going to lose Jane.*" (219) Both he and Jane link his fear of abandonment to an earlier divorce. His adulterous ex-wife may have been someone other than he thought, in the colloquial sense, but cannot account for his believing in imposters. Thus, while Dave's personal history partially explains Capgras-relevant non-perceptual beliefs, a gap persists. Dave also claims to see animals that others do not see, such as a giraffe in their garden. Aware of these claims to believe things he oughtn't, Jane attempts to minimise the mistakes. She recasts his misidentifying her as a recently deceased brother an effect of grief and the giraffe a misperceived tree. But there is a tension here. She either disavows his explicit claims in order to preserve overall psychological coherence, or accepts his statements as truly reflecting beliefs he ought not to hold. Dave is either silenced or estranged in the process.

IS DAVE IRRATIONAL?

Instances of possible irrationality can be identified in the interview, apparent also to Jane: "*Where he would get the logic of thinking what he is saying?*" (236) Examples of inconsistency about the misidentification include Dave's quotidian interactions with Jane whom he considers an imposter; acknowledging human proportions yet searching the laundry basket for intruders; stating both that he must be ill and completely well; and fearing imminent abandonment while saying she has already departed. Dave seems to tolerate mutually incompatible actions and utterances without undue concern. To maximise interpretability and coherence, Jane invokes unconscious mechanisms such as denial of grief/illness and repression/displacement of historical feelings of abandonment: "*it is subconsciously in your head […] some kind of a security net for you.*" (232)

In *Making Sense of Ourselves*[8] Dennett considers full logical consistency an unnecessarily stringent condition on rationality, preferring a weaker "minimal rationality" as advocated by Cherniak.[9] But how minimal is this minimal rationality? Helpfully, he goes on to describe a case of inconsistency sufficient, from his perspective, to undermine rationality. This involves a customer receiving the wrong change despite a purveyor of lemonade having correctly identified both the money paid and the coins returned. Here we have an instance of irrationality, as the vendor seems to believe he returned both X and Y amounts. Although, for Dennett this is an inapt use of "believe" as the mistake simply cannot be interpreted in folk psychological terms. The vendor cannot be ascribed any beliefs about his action.

> I hold that such errors, as either *malfunctions* or the outcomes of *misdesign*, are unpredictable from the intentional stance [….] If there is no saving interpretation – if the person in question is irrational – no interpretation at all will be settled on.[10]

Dave's inconsistencies are at least as bad as the poor lemonade seller. Jane responds in kind by not settling on any one interpretation but rather entertaining an array of competing possibilities, none of which she finds to her satisfaction. This interpretative instability forestalls communication between them: "*It can be really, really difficult and it is difficult because of not knowing how to answer his questions.*" (240) Frank inconsistency that is objectively obvious while the subject is oblivious is difficult to tolerate but still interpretation goes on. For Dennett, "We make these hypotheses simply on the basis of our abhorrence of the vacuum of contradiction."[11] The psychological story Jane tells of Dave is, for Dennett, just that: a "story."

Dennett predicts patients like Dave are, "unable to reason, unable to communicate," [12] but this seems overly pessimistic. Dave describes his attempts to establish Jane's identity from a group of women: "*what used to protect me is I know that's not Jane, because she is too short, I know that's not Jane because her hair is dark, but not as dark as Jane's. I would figure it out from there and whittle it down to that is Jane there*." (218) However, he acknowledged such attempts were not always successful and clearly something has gone awry with recognition when one must resort to such explicit reasoning to identify one's own wife.

DO OTHERS ADOPT THE PHYSICAL STANCE TOWARDS DAVE'S DELUSION?

Although Dave neither believes exactly what he ought nor displays evidence of gross rational inconsistency, Jane's deliberations on a biological causation are equivocal. For her, medical and psychological explanations are compatible and she successively proffers examples of each without settling on either style of explanation. Despite the interpretative and predictive difficulties she does not unequivocally drop to the design or physical stance, as Dennett recommends she should. She knows that he is ill yet continues to seek a psychologically meaningful explanation for his misidentification of her. Indeed, he does too. While Dennett has stated that intentional stance interpretability is a foundation for personhood, Jane never stops treating Dave as a person despite her noticing his instances of irrationality. Nevertheless, he perceives a fall in his status during interactions with others: "*that to me, that sort of thing gives you the feeling of not being all there, and that makes you really angry because you can't get the words out that you want to say, it won't come out. You feel as though you are definitely a no-no with them, a nothing.*" (223)

Assumptions that the object of interpretation believes everything he ought and conforms to Dennett's standards of rationality are undermined by Dave when discussing his delusion, or indeed his views on whether or not he is ill. He is therefore uninterpretable on these matters from the intentional stance. Dennett's more pessimistic predictions however do not seem borne out. Treating his statements as meaningless also overlooks the striking parallels between his fear of losing Jane and the history of rejection and fear of losing his memory and vitality. Of course, these need not be relevant, but the intentional stance approach ensures they are not; it risks limiting our psychological understanding, which cannot be correct for a method of interpretation. While similarly focussed on rationality Davidson was aware that our potential for irrationality could invalidate his theory, [13] so let us now consider Dave's Capgras' delusion in the light of radical interpretation.

DAVIDSON & CAPGRAS' DELUSION

Davidson recognised his rationality constraints should not be overly restrictive. However, whether or not the Capgras delusion is too irrational for radical interpretation remains an open question. In *Delusions and Other Irrational Beliefs*[14] Lisa Bortolotti notes that Davidson

requires merely that humans be "largely rational" to be granted beliefs but goes on to argue that Capgras' delusion fails to meet the threshold. She worries that a Davidsonian is unable to ascribe Dave the belief, "My wife has been replaced by an imposter." Marga Reimer[15] offers an alternative appraisal of Davidson's radical interpretation. Like Maher and the phenomenologists, Reimer argues that Capgras' delusion is a rational response to an anomalous experience,[16] but an experience *so* odd only an extravagant explanation will suffice. Here she appeals to Ratcliffe's conception of profound estrangement rather than the specific anomaly of neuropsychiatric accounts. Finding a *doppelgänger* of one's spouse is so peculiar that invoking cultural conceptions presented in films such as *The Stepford Wives* is not unreasonable. Typically, imposters are not recognised as such by anyone except their nearest and dearest. By adopting this belief in preference to the one offered by the neurocognitively-orientated psychiatrist the sufferer is not being irrational because biological explanations may sound as alienating and far-fetched as belief in imposters; unless one is already a cognitive neuropsychiatrist! Reimer seeks to demonstrate that the delusional belief is consistent with other beliefs; congruent with the (strange) experience; and coheres with the sufferer's actions, emotions and attitudes. Here therefore are two contradictory readings of Davidson's philosophy as applied to the Capgras delusion. As the debate turns on whether the belief is rational or not according to Davidson's principles of charity, let us examine Dave's delusion with this in mind.

DOES DAVE CONFORM TO THE PRINCIPLES OF COHERENCE?

Davidson takes failure to conform to basic rules of logic as antithetical to interpretation. The laws of identity, non-contradiction, and excluded middle are constitutive of thought for all "thinking creatures." Dave's statement, "*Jane didn't look like Jane, Jane looked like this Jane*" (217) superficially appears to contravene the law of identity, but it is not given this is exactly what the imposter hypothesis attempts to explain. However, whether he errs with the law of non-contradiction is less clear. How can Jane both look unlike Jane and simultaneously look like her? By assuming there are several Janes we can make some sense of this, although Jane seems to refer equally to Jane-proper and her imposter: the extension of that name is ambiguous. This may not amount to a flaw in basic logic but it introduces an indeterminacy that is, at a minimum, perplexing.

The crux of Reimer and Bortolotti's dispute rests on whether the Capgras delusion is well integrated with other beliefs, or not. Dave's Capgras delusion appears partially integrated. He proclaims his beliefs, queries others on his wife's disappearance; infers involvement from their denials; modifies his (presumed) disbelief in witchcraft to accord with the delusion; and evinces distress and bewilderment commensurate with a spouse's sudden disappearance: "*I just don't know it was a terrible, terrible, terrible experience, I mean really bad because it made me cry and it made me, I wanted Jane, I wanted her with me I couldn't bear the thought of her not being there or if she just turned on her heels and walked away from me."* (219) He reasons appropriately that if he is wrong then he must be ill. However, it may be an unbridgeable imaginative leap from knowing he has dementia to experiencing his wife is an imposter, therefore reasonable to doubt its plausibility. Furthermore, Dave's previous experience of rejection coheres with the delusional content if we grant him awareness of diminished vitality, the very reason he gives for his first wife's cuckoldry, "*well there must have been reasons why my wife left but I think the answer was that I wasn't a very go-get guy*." (221) Dave himself gives credence to the idea the delusional content and rejection by his first wife are linked: "*eventually it probably worked its way like a worm in my head and took over and I did have a time like that when I was worried and sick about Jane*." Against this, it is true he resides with an alleged imposter, although not peaceably but every implication of a belief need not be acted upon, and to defend the belief he flouts the Occidental system of belief with his appeal to sorcery: "*you [Jane] are a witch, yous (sic) are all witches and that is how you tell each other…*" (236) Davidson allows for a degree of inconsistency so long as it does not persist when brought to the subject's attention. Inconsistency is permitted because there is some partitioning of the mind; inconsistent beliefs can be logically "isolated" from each another. Dave thus broadly adheres to the principle of coherence and the inconsistency he does show may be of a piece with the self-deception[17] Davidson described as compatible with being "largely rational."

There is an additional form of irrationality Davidson tolerated. A belief can be caused by a mental state that nevertheless is not a reason for that belief: "A simple example is wishful thinking: a desire or wish that a proposition be true causes a person to believe that it is true, but is not a reason for thinking it true."[18] A belief can be ascribed without a rational reason for that belief. Therefore the fear, or wish, that his wife might leave him could be the cause for the delusional content without being a satisfactory reason for it. This accords with some

of Jane's psychological theorising, "*I don't know if you think because you are ill 'she will be gone, she isn't gonna stick around for this.'*" (233) The cause need not be psychological so the irrationality, to the extent it is present, could be accounted by an extra-mental event such as biological disorder: "*I started to think 'have you had a bleed, a bleed on the brain or something?'*" (232) Either option has the potential to account for some irrationality while retaining the capacity to ascribe Dave the belief, "My wife has been replaced by an imposter."

DOES DAVE CONFORM TO PRINCIPLES OF CORRESPONDENCE?

In the interview with Jane she repeatedly raises the issue of poor correspondence between her perceptual experiences and his: "*he could be saying look at the woman standing on the wall with the giraffe under her arm and I would say to him 'well number one, where would she get a giraffe?'*" (235) He questions her on the whereabouts of Jane his wife, and refuses to accept her replies: "*when he says 'so where's my Jane?' and I say 'I'm your Jane' and he says 'no you are not my Jane' and he says 'don't start being stupid with me' and it gets to a level where he gets really angry*." (233) These are patently visible and a source of significant conflict. The lack of correspondence cuts both ways and frustrates him as much as or even more so than it does Jane, "*because he says 'I don't understand how you couldn't have seen them' and he says 'I am distressed now, and you are a member of my family and I am asking you and you won't answer the question'*." (234) This lack of correspondence pointed Jane towards suspecting he was unwell: "*saying I was a liar, why was I saying that? And I didn't know whether maybe he could have had a urine infection or something.*" (230) From the perspective of radical interpretation, problems with correspondence may not undermine meaning to the same extent as coherence, but they look to be readily apparent to carers and indicative of possible mental disorder. Is the non-correspondence sufficient to question Dave's background rationality? Certainly, Jane continues to treat him as a rational agent and attributes intentionality to his actions generally and his imposter beliefs specifically, stating for example that he looks in the laundry basket for hidden intruders. While wondering aloud how he came by his beliefs, she never questions their status as such. Indeed, even where she fails to comprehend Dave she maintains, "*Whatever it is he obviously knows what he means himself*." (242)

His behaviour, his distress, his statements, his puzzlement only makes sense when it is granted he does indeed believe his wife has been replaced. Coherence is better preserved than correspondence although this still makes the attribution of meaning rather less determinate than for fully integrated beliefs. And to the degree that his beliefs are irrational, an additional causal factor is implied. But this does not disqualify Dave from being a rational agent, from the Davidsonian perspective. Wittgenstein's notion of agreement in judgement is somewhat similar to Davidson's principle of correspondence, as speakers should agree on what it is they can both perceive in the immediate environment. However, for the former rationality does not ground interpretation but is itself a manifestation of our particular mode of existence.

WITTGENSTEIN & CAPGRAS' DELUSION

On Certainty touches upon various aspects of psychopathology. Although not referring directly to the Capgras delusion, many comments are intriguing. The permanence of objects such as mountains and books is discussed and it is proposed that constancy of identity is a hinge proposition inculcated early.

> Just as in writing we learn a particular basic form of letters and then vary it later, so we learn first the stability of things as the norm, which is then subject to alterations. §473[19]

One unthinkingly grabs a towel, calls home, cooks dinner, and puts down a book because the constancy of objects are not in doubt. These certainties anchor language.

> If I say "this mountain didn't exist half an hour ago," that is such a strange statement that it is not clear what I mean… Only the accustomed context allows what is meant to come through clearly. §237[20]

Where certainties become doubted it becomes impossible for others to understand the basis of the doubting.

> To have doubts about this would seem to me madness – of course, this is also in agreement with other people; but *I* agree with them. §281[21]

The latter quotation invokes the notion that language-games take place within a community who share a culture and education. Only some doubts are "reasonable" within such a group. Others are, so to speak, outlawed: "The reasonable man does *not have* certain doubts. §220"[22] An example given involves doubting a close companion's identity.

> What could make me doubt whether this person here is N.N., whom I have known for years? Here a doubt would seem to drag everything with it and plunge into chaos. §613[23]

The case in fact involves doubting a name, but coming to doubt N.N. *is* N.N. is no lesser matter. Recall that Campbell explains the Capgras delusion utilising Wittgenstein's notion of hinge propositions: an abnormality directly affects hinges concerning spousal identity, thus explaining the indubitable certainty with which it is held. The conviction that one's spouse is an imposter begins to operate as a hinge proposition. As hinges ground all thinking and action, a change in the foundation alters their basis, and hence, their very nature. Thus, one can neither reason with nor understand the Capgras patient whose aberrant experience of the world is incommensurable with others.

> I should not understand where a doubt could get a foothold nor where a further test was possible. §356[24]

> One might simply say "O, rubbish!" to someone who wanted to make objections to the propositions that are beyond doubt. That is, not reply to him but admonish him. §495[25]

So, from the Wittgensteinian perspective, the Capgras delusion should be unintelligible to others and impervious to reason. However, a virtue of Wittgenstein's *On Certainty* is the additional consideration of the first-person subjective consequences of such doubts.

> "Do I know or do I only believe . . . ?" might also be expressed like this: What if it *seemed* to turn out that what until now has seemed immune to doubt was a false assumption? Would I react as I do when a belief has proved to be false? or would it seem to knock from under my feet the ground on which I stand in making any judgments at all? – But of course I do not intend this as a *prophecy*.
> Would I simply say "I should never have thought it!" – or would I (have to) refuse to revise my judgment – because such a 'revision' would amount to annihilation of all yardsticks? §492[26]

In the Capgras case, spousal identity shifts from a being a matter of unreflective certainty to one open to doubt. Or, alternatively, the spouse's identity moves from beyond doubt to a certainty with regards his or her non-identity. Wittgenstein did not intend to predict the outcome of such a change in hinge beliefs, however it is clear that he considered it potentially catastrophic to the doubter. In the example above where N.N.'s identity is uncertain: "In that case the foundation of all judging would be taken away from me. §614"[27] The most basic of judgments are undermined.

> Wouldn't a mistake topple all judgment with it? §558[28]

> Certain events would put me into a position in which I could not go on with the old language-game any further. In which I was torn away from the *sureness* of the game. §617[29]

While judgment may be undermined by the loss of certainties, will the sufferer be aware of this loss? In a different context, Wittgenstein discussed this point.

> I believe that there is a chair over there. Can't I be wrong? But, can I believe that I am wrong? Or can I so much as bring it under consideration? §173[30]

His rhetorical question invites the reply that, "No, I cannot believe my belief is wrong. For it is the nature of beliefs to be believed. The suspect belief is no belief." The Capgras patient still has certainties and doubts but many of these differ from his interlocutor's. Therefore, it appears that a different language-game is being "played."

> This doubt isn't one of the doubts in our game. (But not as if we *chose* the game!) §317[31]

Different language-games are thus opposed, the patient versus the carer and clinician (although the patient-carer and patient-clinician are involved in their own differing language-games.)

> If we call this "wrong" aren't we using our language-game as a base from which to *combat* theirs? §609[32]

> Where two principles really do meet which cannot be reconciled with one another, then each man declares the other a fool and a heretic. §611[33]

So we have two possibilities suggested by *OC*. On the one hand, the Capgras sufferer may stop judging altogether. He may be "plunge[d] into chaos." Alternatively, he may play a different language-game, one incommensurable with his peers. Let us turn to Dave and Jane's interviews with these possibilities in mind.

ARE HINGE BELIEFS IMPLICATED IN DAVE'S DELUSION?

"*[T]here was a lot of these people especially the women, I look at Jane and um Jane would disappear and another girl would come along.*" (217) Dave's doubt about Jane's identity does not neatly involve just one type of Mayol-Sharrock's hinge belief.[34] Rather, universal, local, personal, and linguistic hinges are all implicated. It is universally held that identity persists over time, as Wittgenstein illustrated in his talk of spontaneously materialising mountains; Western educated people generally discount a role for witches in their daily lives (which Dave does not); both Dave's autobiographical and perceptual experience of Jane are fundamentally altered ("*then when Jane came back it was just something that wasn't the same*" (217)); and, it could be argued, his facility with the words "*wife*" and "*disappear*" is impaired given he fails to act fully on their implications. Dave comes across as less certain than one might suppose if the proposition "that woman who looks like my wife is instead an imposter" operated for him as a hinge-belief. He is clearly not certain. Dave acknowledges he could be in error and therefore ill. "*Well yes it backs up whatever it is and whatever the*

others are thinking, whether you are thinking that or not." (227) The delusion seems to be the basis intermittently for action rather than consistently, pre-reflexively, and with the sureness associated with hinge propositions.

DO DAVE'S JUDGMENTS AGREE WITH OTHERS?

When directly questioned about the use of language, neither Dave nor Jane reports any problems with comprehension of words and phrases. Indeed, Jane praises Dave's facility with language and says: "*No I can always understand what he is saying. I mean it could be Gobbledegook, but…*" (234) It is *why* he says what he does that she cannot understand. Jane cannot grasp his reasons. She does not "understand where a doubt could get a foothold" [35] here. His beliefs about imposters strike Jane as unsupported by evidence: "*When I say some of it is hard to understand it is more about where he would get the logic of thinking what he is saying*." (236) Jane discusses her inability to reason with Dave. Sometimes she attempts but fails: "*Trying to make logic of what the conversation is and you actually just get so exhausted and think, 'Ahhhhhh, it will stop in a few minutes.'*" (236) While at other times she is simply disparaging: "*I have sat down haven't I with you and said, 'Look how ridiculous this is!'*" (237) That is, she admonishes him. For Jane, his misidentifying her as an imposter can be no mere mistake, as that, for her, is ruled out here. They cannot agree on what is true and what is false and even disagree on what counts as evidence in the matter. So, does Dave's refusal to engage in justification represent a different form of life incommensurable with Jane's? Despite appearances, it seems not. Recall that: "In the beginning was the deed."[36] Yet shared practice does not break down quite as fundamentally as one might suppose from the discussion above. Jane continues to provide love, care, and cups of tea, which Dave appears, by-and-large, to accept. Furthermore, the vast bulk of their conversation proceeds without event indicating that the difficulties arise against a background of shared judgements and meanings. Dave does not possess his own private language nor does he represent an incommensurable "form of life." Acting precedes reason so their ability to share a life suggests a fundamental system of thought has been preserved.

> I want to regard man here as an animal; as a primitive being to which one grants instinct but not ratiocination. As a creature in a primitive state. Any logic good enough for a primitive

means of communication needs no apology from us. Language did not emerge from some kind of ratiocination. §475[37]

WHAT ARE THE SUBJECTIVE CONSEQUENCES FOR DAVE?

Wittgenstein considered the first-person perspective: either all judgment would be undermined or an entirely different language-game would be played and certainty sustained. What actually happens for Dave is however not quite what the dichotomy predicts. On the one hand, as we have seen above, there is no convincing evidence of an incommensurable gap between Dave's language and his community. Dialogue has been hindered: "*I never tried to get any knowledge from one of them, the other one would stand beside her and they would look at each another and sort of um, yeah yeah yeah, blah-blah and leave me there, and it would make me feel sort of not quite there.*" (219) Dave is searching for certainties rather than acting upon idiosyncratic ones: "*That is what you do and plus you carry on with anything else you can get your hands on*." (227). While on the other, the experience is clearly troubling for him – "*a terrible, terrible, terrible experience*" (219) – and it leads him to suspect his sanity, for if he is wrong about this then he can no longer trust his judgement: "*well it means that I had it then, doesn't it, it must mean that I had dementia then which I didn't know anything about*." Although even this is tentative: "*um, well it wouldn't always be in illness, would it?*" (227) His fear about being wrong thus points more towards the side of doubting all judgement, even if it is not quite so extreme as Wittgenstein foretold. Dave is well able to appreciate his dilemma: "*well what else can you do, what else can you think, you either believe what you are seeing or what you are being told and put it against you and what you think you believe and what you are being told. Sometimes the things you are being told you don't understand anyway, so you are in trouble immediately*." (228)

The Wittgensteinian perspective on the Capgras delusion seems to suggest that there is yet something unfathomable and unreachable about the experience and the words used to describe the beliefs. And yet despite this, not all communication is plunged into chaos. Life continues, tea is brewed, and appointments are kept. That they can carry on despite the difficulties shows that a form of life is shared and indeed it is this that enables one to appreciate the extent of Dave's illness and distress.

CASE 2: LIZ

DAVIDSON & VISUAL HALLUCINATIONS

It is natural to consider whether hallucination would be understandable within radical interpretation given the principle of correspondence. This principle states that an interpreter must grant most of the speaker's beliefs about the environment to be true and "the speaker be responding to the same features of the world that he (the interpreter) would."[38] This charitable principle obviously does not hold in hallucination where the sufferer is responding to non-veridical worldly features. Relatedly, Davidson[39] described a person who appears to misperceive a feature of the environment: a hat on the floor is said to be a cat, for instance. Two options present themselves to the interpreter. She can either conclude that the speaker has experienced an illusion, or that he meant to say "cap" but misspoke. These re-descriptions are charitable because they are rationality preserving. However, neither is available when discussing hallucinations as i) there is no object to stimulate an illusion and ii) further questioning would reveal that he did indeed say "cat." Nevertheless, Davidson tells us that false perceptual beliefs are not devastating to radical interpretation as "small perturbations against a background with which we are largely in sympathy"[40] can be accommodated while logical inconsistency cannot. If someone were to live in a permanent state of extended scenic hallucinations, could we interpret her? Davidsonian radical interpretation would seem to suggest not, although the focus on vision in Davidson's writings underplays the shared tactile and auditory components of perception. We understand the blind and even the insensate once these deficits are taken into account. Given the involvement of shared perceptual experiences we look first at the principal of correspondence before turning to coherence.

DOES LIZ CONFORM TO THE PRINCIPLES OF CORRESPONDENCE?

"*The flowers on my window sill they dance and I think to myself what is going on and then I see people in my place on bikes, walking around. But they never talk, they just laugh*." (246) These unshared visual experiences have placed Liz at odds with her family. "*No one believes me… It feels nasty; it makes you feel you're a liar.*" (259) The majority of the hallucinations occur at home and are objects and figures seen within a veridical setting. She is aware of the discrepancy between her own visual experiences and those of others. When describing the

oversized cat she could see from her hospital window she acknowledged, "*It was so big I couldn't believe it, but my family couldn't see it*" (258) But this awareness does not lead her to question her own experiences: "*When my daughter said there was nobody in that house I said, 'Yes there is!'…. No, I still didn't believe my kids*." (259) As Liz and her family are responding to many of the same features of the world there are, perhaps, sufficient perceptual anchoring points for interpretation to be broadly unaffected. The similar response-pattern is grounded in shared biology of perceptual systems, so an interpreter may react to false-perceptions by hypothesising a dysfunction. Her friends and family have clearly taken the view that her unshared visual perceptions signify mental disorder. They doubt her claims and she, in turn, distrusts her family's. Communication on the matter has been terminated. "*So that is why I don't talk about it to outsiders. It's alright you're a doctor. I am talking to you, but I couldn't go home and tell 'em or sit around the table and say something, I couldn't tell 'em*." (262) So it would appear that we can ascribe content and meaning to what Liz says about the hallucinations, but the lack of correspondence with her family is a significant problem for trust, if not for interpretation.

DOES LIZ CONFORM TO THE PRINCIPLES OF COHERENCE?

Liz displays numerous inconsistencies, often juxtaposed: "*I live on my own and it is very scary... when you know that you have to watch everything in your home... not really scared, because they are my animals I have had them so long… but it is just the noise and the laughter what frighten me… well why should it be scary? I know it is only animals…. it frightens me…*" (248) During the course of the interview Liz says both that the perceptions are "real" and a consequence of brain damage; she claims the dolls move despite acknowledging its impossibility; she is simultaneously frightened and unperturbed; and she wants the dolls removed and a tablet to cure her. Davidson found such "synchronic inconsistency" irrational for it:

> Requires that all beliefs, desires, intentions, and principles of the agent that create the inconsistency are present at once and are in some sense in operation – are live psychic forces. It is by no means easy to conceive how a single mind can be described in this way.[41]

Liz is inconsistent, yet we can still understand what she says, attribute content to it, and even, to some degree, appreciate its cause. She is confused by what is happening – "*and I know, I know it can't be true, animals don't talk to you unless they are real, but mine do*" (246) – while her inconsistency follows a coherent pattern. Either the dolls are animate, which frightens her and causes her to run, or she is hallucinating because there is a problem with her brain, so she is in need of medications. She is ambivalent and bewildered, not logically inconsistent: "*No it is all in my mind, it has got to be […] but in other ways I say to myself 'no they are not laughing, how can a doll laugh?' It has got no battery or anything on them […] but how does the flowers dance? They are only artificial*." (248) However, she does not apply the principle of conservation: change as few beliefs as possible in light of new experiences. This despite having been given a reasonable and conservative explanation for the phenomena, which she partially accepts. "*I died and they brought me back but it has left this part of the brain no good, not working. That is the cause.*" (246) "*They just said 'your brain is dead, on the left side.' That is all I have been told… but it is not the full explanation*." (253) Lack of coherence is an irredeemable failing in the eyes of radical interpretation; however, Liz's flagrant inconsistencies do not seem to undermine our interpretations of her. It may be she exhibits sufficient background rationality to enable this irrationality to be apparent.

While content can be ascribed to her speech and her actions, radical interpretation tells us nothing about their origin or their psychological import for Liz. Despite Davidson's defending some core Freudian concepts – the partitioning of the mind, a structure in each quasi-autonomous partition, and non-logical causal relations between these parts – radical interpretation offers no insight into their personal significance, or whether there is any. This corresponds with Davidson's scepticism towards scientific psychology generally: "There are no strict laws at all on the basis of which we can predict and explain mental phenomena."[42] Dennett on the other hand writes of visual hallucinations as betraying deep psychological issues, akin to dreaming. We turn next therefore to the intentional stance and its approach to Liz's visual hallucinations.

DENNETT & VISUAL HALLUCINATIONS

Dennett, possibly in homage to Descartes, begins *Consciousness Explained* contemplating the implications of hallucination.[43] He doubts complex and vivid hallucinations are possible; qualifying his scepticism by declaring that where they do occur sufferers must display "unusual passivity."

> The reason these hallucinations can survive is that the illusionist – meaning by that, whatever it is that produces the hallucination – can count on a particular line of exploration by the victim – in the case of total passivity, the *null* line of exploration.[44]

Dennett, *à la* the PAD model,[45] presents perception as a combination of bottom-up sensory input and top-down hypothesis testing. Hallucinations are a consequence of normal hypothesis testing receiving inappropriate confirmation. Thus, sensa incorrectly validate the hypothesis "that's a snake", producing a hallucinated snake: so far, so neuropsychological. Dennett, however, considers that the hypotheses generated reflect anxieties, concerns, and expectations that are betrayed by the hallucinatory content, as with dreams.

> Hallucinations are usually related in their content to the current concerns of the hallucinator, and this model of hallucination provides for that feature without the intervention of an implausibly knowledgeable internal storyteller who has a theory or model of the victim's psychology.[46]

Hence, Dennett is able to meaningfully link content and individual psychology without recourse to Freudian dynamics. This discussion of hallucinations is not a fully formed theory but, as for Descartes, the first move in an account of consciousness. Nevertheless, it is clear that Dennett considers hallucinations to be meaningfully related to a person's deepest needs and desires.[47]

The intentional stance assumes that the system to be interpreted holds (mostly) true beliefs about its environment. Where false-beliefs occur a special story explaining their origin is required, and Dennett gives hallucination and illusion as examples. So hallucinations produce a false-belief but they are "grown in a culture medium of true beliefs."[48] Thus, it is perfectly acceptable to attribute a false-belief that cites hallucination as its cause. When such special stories extending the intentional stance beyond its belief/desire/action base are told, they become inductively learned empirical generalisations. So although hallucinations are commonly regarded as perceptual error, this perspective is not obligatory. Refinements to folk psychology are "parochial."[49]

DOES LIZ BELIEVE AND DESIRE WHAT SHE OUGHT?

The immediate answer to this question is no; Liz clearly holds some rather particular attitudes towards her environment that could not be predicted by an objective observer compiling a list of beliefs she ought to hold, given her place in the world. Liz seems at times to believe her artificial flowers can dance and her collection of dolls is laughing at her: "*my animals, my dolls that sit on my bed. Now I have taken them off and put them in black bags, but you go to bed and you can still hear them […] laughing… and making noises.*" (246) But the intentional stance allows for contentful false-beliefs via the special story of hallucination and most of what she ought to believe she does, i.e. she is in London, in her house, and these are dolls and flowers. There is a plentiful "culture medium" of true beliefs. So while Liz does not believe everything she ought, this cannot here undermine the interpretation of statements related to the hallucinations. As, however, the presence of hallucinations is unpredictable from the intentional stance, Dennett drops to a physical/design level neuropsychological model to explain their origin. Liz is aware that aspects of her false-beliefs contradict various long-standing non-perceptual beliefs, which appears to impugn her rationality.

IS LIZ IRRATIONAL?

Liz appears to act by-and-large in conformity with the hallucinations: "*so now I go to bed with earplugs in and all the dolls and that I put in a black bag and tie the black bags, but I lay there and listen, I listen and I take my ear plug out and I can hear them and I put them back in again.*" (252) This belies Dennett's description of those suffering hallucinations as

unusually passive. Liz also reasons that the hallucinated experiences must be real as a consequence of the objects' perceived agency. They materialise when she is on the verge of sleep and vanish on request, "*because it is so funny how they can get in and when you tell them to go, they go*."[‡] (250) Extrapolating from her cultural background and personal history, dancing flowers and animate dolls should be implausible, and they strike Liz as such too: "*how can a doll laugh? It has got no battery or anything on them*." (248) "*Why does dolls who haven't got no press buttons on them can sit there and laugh.*" (252) She is aware of this tension between what she perceives and what she knows, but is swayed towards the former: "*I know it can't be true, animals don't talk to you unless they are real, but mine do!*" (246) Liz does not resolve this contradiction but she acknowledges it. Indeed, she draws some inferences, recognising that either these visitations are real or indicative of illness: "*Now this part of the brain is not working. It's me, I imagine things, I have got to*." (248)

For all this coherence, Liz found most hallucinatory scenes inexplicable. She explicitly denied any relation to memories or personal experiences and questioned their relevance: "*Big frilly ball gowns… why I have never been to a ball place in my life*." (249-50) That she could not recognise individuals other than twice seeing her late husband was a further confusion for her. Some images, however, were portentous: "*I don't know, perhaps it's time for me to go*." (250) Excepting that "angels" might signify death, Liz's own concerns are unrecognisable in the stereotyped hallucinations that constitute the majority. Nevertheless, the scene with the injured boy outside the hospital has a dream-like quality that is tempting to read as relevant to her concerns, as Dennett suggests: "*Someone just run him over and I wanted to jump out the window to pick him up. So what was all that? And I remember this house, it had a black street door and as you opened this street door you must have been in the living room, it was all red furniture and she had a black and white cat. It was so big I couldn't believe it.*" (258) She could perhaps identify with an injured child in need of rescue, as she had been when placed in a children's home then again following her cardio-respiratory arrest, and the image of the black doorway is funereally evocative of death.

[‡] This is quite consistent with peduncular hallucinations, which tend to be triggered by states of drowsiness and respond to commands to leave.

DO OTHERS ADOPT THE PHYSICAL STANCE TOWARDS LIZ'S HALLUCINATIONS?

Where the intentional stance fails, Dennett moves to the physical stance. For Liz, these alternatives are in tension. On the one hand, she acknowledges that she sees things due to an error in her perception and that doctors consider them hallucinations: "*Now this part of the brain is not working!*" (248) Yet still she cannot accept it, disparaging the brain scan and the explanations she has heard thus far: "*They don't tell you nothing what's going on up there.*" (253) Thus, for Liz and her interlocutors, the seeming inexplicability of her experience points to a physical level explanation. But rather than conceding this move she prevaricates. "*I always think why is a part of your brain dead? But you've got, you can still do things, you can still talk, I mean I have known people, well Valerie had a really big heart attack and they have lost her brain a bit, but they still carry on. Why can't I still carry on?*" (254) Physical level explanations are alienating in self-interpretation because the assumption of rationality cannot coherently be withdrawn from oneself. Declaring oneself fundamentally irrational from the intentional stance raises complexities similar to the liar's paradox: if true then, despite appearances, it is meaningless; if false it is self-contradictory. Liz is bound to intentional stance level explanations of herself so must reject accounts that impugn her rationality. While personhood is not withdrawn wholesale friends and family evidently mock Liz, from her description of their interactions. She has withdrawn and compares herself with mentally ill people she has met. Although the comparison seeks to highlight differences between her and those who are "*off [their] rocket… mental*" (264), still, it is not a comparison she would have entertained previously.

The intentional stance signals that hallucinations are pathological while allowing the resulting false-beliefs to be readily communicable. It even points to the hallucinated content being psychologically significant without clarifying how these concerns might be symbolised or interpreted in practice. Wittgenstein on the other hand wrote explicitly about the interpretation of dreams and hallucinations. How would he fare with Liz's hallucinations?

WITTGENSTEIN & VISUAL HALLUCINATIONS

Wittgenstein, it will be recalled, expressed ambivalence about Freudian interpretations for their beguiling ingenuity. Fittingly, many of his comments relate to Freudian interpretations

of dreams and hallucinations. Wittgenstein doubted whether every dream and hallucination must originate in wish-fulfilment, or indeed have an origin at all. By viewing the content as symbolic, one cannot but interpret. Wittgenstein however suspected there could be many other psychological reasons for that particular content having arisen, or none. So the hallucination may symbolise anything, or nothing.

> Suppose a starving man has a hallucination of food. Freud wants to say the hallucination of anything requires tremendous energy: it is not something that could normally happen, but the energy is provided in the exceptional circumstances where a man's wish for food is overpowering. This is a *speculation*. It is the sort of explanation we are inclined to accept. It is not put forward as the result of detailed examination of varieties of hallucinations.[50]

> Freud would ask: "What made you hallucinate that situation at all?" One might answer that there need not have been *anything* that *made* me hallucinate it.[51]

The allure of Freudian analysis, he explained, is twofold: i) dreams and hallucinations give the (false) impression of being a symbolic language, and ii) the subject accedes to the wish-fulfilment interpretation to prove an initial prejudice in thinking has been overcome. But just because one takes the top hat as phallic symbol does not mean this is the way it was intended in the hallucination. The wish-fulfilment hypothesis precludes alternative readings.

> There is an inducement to say, "Yes, of course, it must be like that." A powerful mythology.[52]

Wittgenstein's criticisms of Freud do not amount to a theory or explanation for dreams and hallucinations. Wittgenstein's advice would be to leave everything as it is for risk of imposing an interpretation that does damage to the original experience. Such an experience would, for Wittgenstein, be quite devastating.

> What if something *really unheard-of* happened? – If I, say, saw houses gradually turning into steam without any obvious cause, if the cattle in the fields stood on their heads and laughed and spoke out comprehensible words; if trees gradually changed into men and men into trees.

> Now, was I right when I said before all these things happened "I know that that's a house" etc., or simply "that's a house" etc.? §513
>
> This statement appeared to me fundamental; if it is false, what are "true" or "false" any more?! §514[53]

Wittgenstein would have been unmoved by physiological accounts, such as the PAD model, as these are conceptually independent of the act of interpretation. Technological advances over the intervening years could not have persuaded Wittgenstein otherwise. According to the Wittgensteinian perspective then one can anticipate that the hallucinated content will cry out for interpretation by the sufferer. Simultaneously, the hallucinating person will doubt what was once certain to the detriment of language-games: "One is not playing the game, or is playing it wrong, if one does not recognize objects with certainty. §446"[54] Or, indeed, recognises with certainty what others cannot see.

ARE HINGE BELIEFS IMPLICATED IN LIZ'S HALLUCINATIONS?

The content of the hallucinations does often seem to contravene universal and local hinge beliefs: people do not suddenly appear and disappear; inanimate objects cannot move and laugh, nor flowers dance; seven-feet tall women do not suddenly appear in bedrooms: "*Then I have had women in my place, and they looked so tall and I just think to myself, 'Who are you?' I don't know none of them […] I would say about seven foot if you are lying in bed and looking up, her head was nearly reaching the ceiling and I, I get panicky*." (247) Liz is aware such things are impossible or implausible – "*I know, I know it can't be true*" (246) – yet still tends to accept their veracity – "*I can see it plainly*." (250) That the content contravenes hinges is part of her reasoning for why the experiences cannot be acute: "*in other ways I say to myself no they are not laughing, how can a doll laugh?*" (248) And may account for how they stand out against true perceptions. For instance, the women's height and attire strike Liz as discordant with local and autobiographical hinges. "*They have just got old fashioned clothes on, yeah old fashioned […] what they wore in the 20's, like the big padded shoulders and all this garment they wore […] it is like all frills what come out and they come round in a big wide square at the bottom, yeah, why I have never been to a ball place in my life.*" (249-50) Whilst in certain respects the hallucinations can be taken as contravening hinges they never seem to operate *as* hinges for Liz. They do not form a stable basis for action or

thought but rather sow distrust, puzzlement, and equivocation: "*and I think to myself, 'What is going on?'*" (246)

DO LIZ'S JUDGMENTS AGREE WITH OTHERS?

The interview with Liz does not reveal any systematic problems in her use of words and language. We, and one presumes her family, can understand exactly what she says: we understand her claims. The only potential problem is her description of what can be seen from the hospital room. "*I remember this house, it had a black street door and as you opened this street door you must have been in the living room, it was all red furniture and she had a black and white cat. It was so big I couldn't believe it. But my family couldn't see it*." (258) Liz seems to be describing an experience somewhat unlike normal vision, if one can see into front rooms well enough to describe the domestic pets, residents, and furniture from a hospital window. But, on the other hand, she denies that her descriptions are in any way metaphorical or analogical: "*I see 'em! I definitely see 'em!*" (259) Liz does not appear to notice the discrepancy between what it is possible to see and what she reports having seen. This puts pressure on her use of these words for the limits of sight are part of its definition. One cannot see in the dark or round corners. This partly forms the concept of sight and seeing.

A more pertinent issue for her and her family, however, is the failure of agreement concerning perceptual judgments. This is rather analogous to Davidson's principle of correspondence, though goes beyond it. For Davidson it is the truth of perceptual beliefs that is at stake whereas for Wittgenstein agreement in judgment concerns what counts as evidence. The failure to find agreement looks to have destabilised familial trust, "*and then they will say 'you are going loopy,' that is what they will turn around and say, so I say, 'alright, forget it.'*" (264) Some quality of these apparitions is so compelling that it undermines the maternal bond and overrules established facts. She is now able to confide in only one friend who had a similar experience of hallucination following bereavement. Liz asserts that her ability to describe the figures in detail and their displays of agency as proving their existence. Whereas one imagines that for her family it is precisely these features that confirm their misgivings. The outcome is antagonistic interactions: "*I don't… try to make them understand or nothing no. Because they will only stand and laugh, and I don't*

like that because I have got a temper and I could do something dangerous." (261) Correspondingly, Liz does not concur with medical judgments. She acknowledges a history of strokes and suspects they may be connected with her changed state: "*I have never been like it in my life […] I can't prove it, but I have got to have proof done on me to see if it is.*" (249) Despite being told of her neurological injury, she distrusts the messenger and the message: "*But are they only saying it, I do not know, but when I had the head scan done here, they said that it was my left side that's gone dead […] but it is not the full explanation*." (253) The disagreements, however, do not appear to be of the nature that Wittgenstein says language and meaning relies upon. Her difficulty accepting that part of her brain is "*dead*" is founded on a narrow definition of the word. One, however, that accords with her peers who agree that a part of the brain being dead should be incompatible with speech. "*Me friends don't understand, they laugh at me, 'How can your brain be dead if you are still talking?' Which is right, I say*." (255)

WHAT ARE THE SUBJECTIVE CONSEQUENCES FOR LIZ?

Liz, although obviously isolated, does not collapse into doubting all judgment, as Wittgenstein had seemed to suggest. She does though cast about for explanations and interpretations for the hallucinated content: "*I don't know, I have been asking myself "Why?" […] I don't know, it is hard to think, what is the laughter, why are they laughing, I don't know. I wish someone would tell me.*" (249) The angel-like apparitions are provisionally interpreted as symbolic of her death: "*I don't know; perhaps it is time for me to go, I don't know*." (250) The spiritual interpretation by a friend who has had similar experiences only compounds her bewilderment, "*So I said, 'That was nice,' but she said, 'It wasn't my mum,' so I said, 'Who was it then?' She said, 'I don't know, it didn't even look like my mum.'*" (256) Alongside her drive to interpret is a suspicion that the explanation lies in an undisclosed neurological disorder: "*What I want to know myself if someone has got the guts in them to come and tell me actually what is wrong with this part of the brain.*" (265) But worse is dread that the experiences denote mental disorder – "*I don't want to be one of these people who go mad*" (253) – just like her father: "*me dad he was a good old stick, but he went mental.*" (267)

The principle problem for Liz is a lack of agreement with others about the immediate environment and the relevance of her evidence. This causes a rupture in relationships that has left her demoralised and angry, though not so doubting of everything as Wittgenstein intimated. Where the stark choice is between viewing herself as "mad" or others as lying, Liz displays a bias towards the latter. Wittgenstein of course criticised the Freudian orthodoxy of dream and hallucination interpretation. They may sometimes be wish-fulfilments, but there may be other psychological reasons for the content and indeed for the hallucinations occurrence. This purely negative thesis cannot help us understand why Liz sees what she does. The seven-foot-tall angel-like apparition is a case in point. That she be watched-over during illness and adversity, something she did not experience from her own mother but likely wished for, is open to Freudian analysis. Because the interpretation fits – "Yes, of course, it must be like that"[55] – does not mean it is correct, however. But the allure of interpretation can explain Liz's incessant quest for answers. The images are so charged with possibility yet obscure that there can be no decisive interpretation. Liz also seems to concur with Wittgenstein that physiological level explanations are irrelevant to interpretation – "*I've had scans on me head the other week in the hospital, but they don't tell you nothing what's going on up there*." (253)

CASE 3: JOHN

WITTGENSTEIN & CONFABULATION

Wittgenstein makes remarks in *OC* uncannily reminiscent of confabulations. Consider:

> Could we imagine a man who keeps on making mistakes where we regard a mistake as ruled out, and in fact never encounter one?
> E.g. he says he lives in such and such a place, is so and so old, comes from such and such a city, and he speaks with the same certainty (giving all the tokens of it) as I do, but he is wrong.
> But what is his relation to this error? What am I to suppose? §67

> If my friend were to imagine one day that he had been living for a long time past in such and such a place, etc. etc., I should not call this a *mistake*, but rather a mental disturbance, perhaps a transient one. §71[56]

Thus, erroneous claims about one's past are not mistakes as these are inconceivable here. Such errors indicate mental disorder. But why is a mistake ruled out? What is it about this error that signals disorder?

> Can we say: a *mistake* doesn't only have a cause, it also has a ground? i.e., roughly: when someone makes a mistake, this can be fitted into what he knows aright. §74[57]

So a mistake is consistent with and supported by other beliefs held by that person but a confabulation is not. Knowing what counts as evidence for and against a belief, understanding what counts as valid grounds is also consistent with making a mistake. Such determinations require the application of reason and agreement in judgement.

> In order to make a mistake, a man must already judge in conformity with mankind. §156[58]

So "mental disturbances" such as confabulations are evident to others because the reasons given for holding the belief are either lacking or inappropriate by an observer's standards. Moreover, for Wittgenstein such mistakes raise doubts about the meaning of the stated belief and carry implications for all judgment.

> "If my memory deceives me *here* it can deceive me everywhere."
> If I don't know *that*, how do I know if my words mean what I believe they mean? §506
>
> "If this deceives me, what does 'deceive' mean anymore?" §507
>
> What can I rely on? §508[59]

These quotes indicate the catastrophic consequences for the person aware of making such mistakes. If one can be deceived about this then one is thrown into radical doubt.

> If I say "I have never been to Asia Minor," where do I get this knowledge from? I have not worked it out, no one told me; my memory tells me.- so I cant be wrong about this? Is there a truth here which I *know*?- I cannot depart from this judgment without toppling all other judgments with it. §419[60]

Now let us explore Wittgenstein's speculations on fundamental error for John and Cath's efforts to understand his confabulations.

ARE HINGE BELIEFS IMPLICATED IN JOHN'S CONFABULATIONS?

John makes a number of statements that would have troubled Wittgenstein. Asked about his recent whereabouts he appeared unaware of being in hospital: "*Well it is an ordinary house, um they have a 3 people or something, it's kind of like a restaurant come whatever, that is what I think, so, and the lad told me yesterday, um last night, he took me in and he was very nice, cos I had no place*." (274) That he does not know where he lives, where he has been, who his family are, whether he works or is a pensioner, and that he is ill seem to contravene personal hinges, both autobiographical and perceptual. Recall Wittgenstein's reflections on Moore's claim to know he has a hand.

> If Moore were to pronounce the opposite of those propositions which he declares certain, we should not just not share his opinion: we should regard him as demented. §155[61]

Yet this is exactly what John does. To Cath this all indicates pathology: "*I think they done an x-ray and part of his brain, there is something wrong with part of his brain*." (295) Just as it would for Wittgenstein:

> N.N. cannot be mistaken about his having flown from America to England a few days ago. Only if he is mad can he take anything else to be possible. §674[62]

The majority of John's confabulated statements could be true; it is only because we know of his particular circumstances that we apprehend their falsity. There are a few instances when local hinge look to be disregarded. When faced with the information he is a hospital patient he incorporates it into his confabulations but fails to recognise the implausibility: "*in a hospital and he lives in it and the whole family lives in it […] and this is a hospital, it's nearly all hospitals [laughs] wherever you go [laughs], I am telling you, I got the shock of my life*." (282) There are no obvious problems with universal or linguistic hinges. Cath remarks that it is impossible to believe he could be the sole survivor of a sinking ship. While improbable, this is not logically impossible so does not contravene a universal or local hinge belief. John's actions suggest he does now doubt what would once have been certain, in keeping with hinge beliefs being dislodged or disrupted: "Our not doubting them all is simply our manner of judging, and therefore acting. §232" [63] John roams from his flat to various personally significant locations, unsure how to find a home.

DO JOHN'S JUDGMENTS AGREE WITH OTHERS?

There appear to be few if any problems with John's use of language. Cath assures, "*yes, yes I know what he is saying… but the problem is that I am not allowed to, which I do when nobody is listening, ask him things about where he has been and all these things he is talking about*." (305) His words are not hard to understand but Cath struggles to know why he makes these particular claims. "*There is no sense in what he says in this last while whatsoever… well he is saying silly things, like he has been to the park today and his kids are small*." (302-3) Again, the problem is more a disregard for personal autobiographical hinges than uninterpretable speech. For instance, when he declares his sister to be the building's landlady she recognises this as a misidentification rather than an idiosyncratic use of the word, "landlady"; although this paraphasic slip might unveil some aspect of their relationship. John's interview also includes word-finding difficulties easily understood as such: "*That is my inten... um... what I think.*" (269) Meaning is not disrupted.

There are, however, significant differences between John's judgments of various kinds and those of Cath. For example, Cath points to John's inability to agree with others on where he is and with whom. He fails to recognise his daughter and his sibship with Cath. He mistakes a hospital ward for a farmhouse and a Health Care Assistant (HCA) for a farmer. These are

disagreements about perceptual judgments; John does not judge in conformity with others. What is worse, his judgments about identity are inconsistently applied. Sometimes he recognises correctly, other times not. There is thus no obvious pattern, further undermining agreement. "*He doesn't know me sometimes and I, I am so close to him, I do everything.*" (295) John is also unable to reliably distinguish the past from the present. "*He went to the park with his kids, with his small kids and they were in the park, this he just said this to me on Tuesday*." (297) When it was put to him that he was in a hospital and not on a farm, his amplification undercuts the argument's effectiveness: "*And this is a hospital? It's nearly all hospitals*." (282) Likewise, when the true identity of the HCA was given, John did not accept the relevant facts: "*Well he seems to be, uh, uh, he is everything, he is a bit of a...[laughs] but any way it is not for me to say.*" (282) This does not conclusively demonstrate John no longer reasons in accord with others. Nevertheless, it raises questions about what counts for him as evidence, how claims should be supported, and beliefs evaluated. They are not mere mistakes.

WHAT ARE THE SUBJECTIVE CONSEQUENCES FOR JOHN?

Recall that, "If my memory deceives me *here* it can deceive me everywhere §506"[64] with the consequence that nothing can be relied upon. John is aware others disbelieve his stories, which induces an inkling of self-doubt. "*Well I've lost the game really but […] at the same time I feel that I haven't told any lies or anything, so he might feel like he has won, maybe he has, but at the same situation I have gained as much ground I think*." (287) He concedes the possibility of fabrication: "*I don't know that I am doing that, maybe I do, maybe I do, I never looked into it, but I can tell a good story [laughs]*." (289) He tends though to accuse others of dishonesty, "*cos I don't tell lies, I don't have to, other people can tell them, I go away and laugh because it doesn't bother me*." (272) But beneath such denouncements seems to lurk an apprehension that he is erring. And he appears to acknowledge that if he is mistaken then a neurological impairment is implied: "*But um I mean what can you do? Um, if somebody tells you something you think it's true, or vice versa. I mean, I never bothered, I was always kinda truthful, and she knows that my sister, so the whole point about is, I don't know what is wrong, I don't think that there is much more, um, they took a scan of this. I haven't heard the result*." (272) John is not in the catastrophic situation Wittgenstein predicted because he fails to accept, for whatever reason, that he is in error. Nevertheless, there is an appreciation that if he is wrong about this, he may be wrong about everything,

hence his concern about the results of the CT scan: "*I don't think that there is much wrong, well they might say there is bits, but there is bits in everybody*." (273)

From the Wittgensteinian perspective, John displays disagreement in judgement. His is no longer in accord with others and rejects personal hinges that previously he acted upon with sureness and certainty. John's obliviousness to these hinges leads Cath to doubt his sanity, just as Wittgenstein worried for Moore's should he have renounced his propositions.[65] However, John's hinge beliefs have not been replaced by others equally certain. Instead, he makes various inconsistent claims that provide an unreliable foundation for action. John is a man whose epistemological rug has been pulled from under him; he endorses anything rather than nothing. Doing otherwise entails disorder. While Wittgenstein was a doomsayer about confabulations, they were tolerated by Davidson and constitute an essential feature of consciousness for Dennett.

DAVIDSON & CONFABULATIONS

Davidson never discussed confabulations directly, however, William Hirstein has utilised Davidson's work on self-deception to draw analogies between the two phenomena.[66] Davidson was interested in self-deception for the principle of coherence implies a degree of consistency not always evident in people's actions and beliefs. Self-deception, for example, presents a paradox.[67] The self-deceiver seems to believe both that *p* and its negation. Deepening the paradox, *p* is the cause of the self-deceptive belief not-*p*. For Davidson, a mark of self-deception is the tension between these two beliefs within the agent. Hirstein, however, denies any such conflict in people who confabulate because:

> The primary difference between the two phenomena is that the self-deceived person often has a greater ability to access the information or processes that are needed to show that his belief is ill-grounded, whereas in the confabulator, the normal routes of access have been destroyed.[68]

Confabulation is analogous to some types of self-deception but monitoring mechanisms malfunction in the former, while the latter involves motivated avoidance of disconfirming evidence. Hirstein then claims that some forms of self-deception, those in which there is no tension between *p* and not-*p*, are in fact identical with confabulation. Furthermore, these states are necessary for humans' survival in a threatening world. We are all confabulating self-deceivers.

> The academic who is far worse than average but believes he is better than average is confabulating if he asserts that he is better than average.[69]

Similarly, Bortolotti invokes the Davidsonian principles of coherence and correspondence in her discussion of the epistemic benefits of confabulating. She remarks that confabulations "exhibit an exaggerated self-serving bias but the majority of people reconstruct memories that are consistent with their desired self-image."[70] So confabulatory content maintains a coherent view of self in the face of neurological adversity by a process similar to one used by everyone. The affirming self-narrative is acquired at the expense of correspondence with reality, and others, however.

> The obvious disadvantage of the preference for coherence over correspondence is that losing touch with reality can create a gulf between the person with delusions and confabulations and her interlocutors… Fotopoulou remarks that in the most serious amnestic conditions there is often a lack of "shared reality" between confabulators and the people who were once closest to them.[71]

Discovering confabulation and self-deception to be similar enables Hirstein, from a Davidsonian perspective, to view confabulations as meaningful, just as the apparent irrationality of self-deception is tolerated despite sub-optimal adherence to the principle of coherence. Bortolotti on the other hand finds the confabulating person to be deficient on the principle of correspondence. For her, however, rationality is no constraint upon meaning so the confabulation remains meaningful. Indeed, it is motivated by preservation of the self.

Nevertheless, should Bortolotti prove incorrect about the rationality constraint then the confabulating person's violation of the principles of charity precludes radical interpretation.

DOES JOHN CONFORM TO THE PRINCIPLES OF COHERENCE?

Davidson averred that the basic rules of logic, such as the law of non-contradiction, be adhered to by all thinking creatures. The paradox of self-deception can only be tolerated when the deceiver does not believe simultaneously both that *p* and not-*p*. John does display closely adjoined inconsistency. For example, he contradicts himself regarding Cath's opinions: "*My sister doesn't think I'm sick… She says, 'Maybe there is something wrong with you.'*" (269) And then, "*My sister says, 'There is not a thing wrong with you.'*" (270) One detects anxiety in John's vacillations and it is possible to provide a Davidsonian picture in which John's fear of illness (*p*) is the cause for his claims to rude health (not-*p*). When John was asked whether others always believe him he seemed able to recognise the unlikeliness of his stories: "*sometimes I find it bloody funny [laughs] myself, you know, things happen that you wouldn't think would happen and people won't, people won't believe you.*" (284) This comment suggests that John can and does consider the plausibility of his confabulated statements, yet fails to reject them. He seems to be getting close to simultaneously accepting both *p* and not-*p*.

Cath judges John's epistemic rationality by comparison with her own. She often claims not to know what he means and even says he "*would be talking all nonsense.*" (309) This is not a failure to understand *what* he means when he speaks but rather *how* he can believe these things: "*Now I don't understand why he is saying things."* (296) However, revoking rationality is not an option for Cath: "*No, no, I go down and sit with him to keep him company and things, no I never, I never give up, no I just let him say them, they are interesting sometimes [laughs].*" (307) For her part, Cath seeks to optimise coherence in John's assertions: "*I can't say that things haven't happened to him in his life, that he got locked in a room in the West End when he was working or something, or maybe not in the West, maybe not even working, but he did work in… he was a security guard.*" (293) She discerns a redemptive quality in his stories, which she enjoys listening to: "*when he was locked in the office he got saved again [laughs], so it seems that he always gets saved [laughs].*" (309) This fits with Fotopoulou's and Bortolotti's view of confabulated content as

maintaining a coherent and positive self-image. Is it at the expense of correspondence with reality?

DOES JOHN CONFORM TO THE PRINCIPLES OF CORRESPONDENCE?

Davidson thought false-beliefs were less problematic for an interpreter than logical inconsistency. When confronted by a speaker with false-beliefs about the immediate environment there is the possibility to revise word meaning to "preserve a reasonable theory of belief."[72] This however does not hold in John's case. His many false-belief claims are taken as genuine rather than his meaning being reinterpreted. For example, when he cannot recognise his adult children, Cath considers it indicative of illness: "*He didn't even know her, he didn't know his own daughter.*" (299) Likewise, his assertions that the ward HCA is a farmer does not cause one to wonder whether this is his preferred term for an HCA. Rather, we immediately attribute to him the false-belief he met a farmer. Where radical interpretation falters, explanations proliferate and then finally cease. Cath clearly generates a number of related and overlapping interpretations and explanations for John, as her IPA interview illustrates. There is mounting uncertainty but she never gives up talking and attempting to understand, "*cos I want to know, to get him, trying to get him back.*" (303) Cath continues to respect John's personhood but calls into question his autonomy and independence due to the illness.

From the perspective of radical interpretation confabulations violate the principles of coherence and correspondence. These violations do not necessarily render John uninterpretable, however, because a degree of self-deception is compatible with rationality and false-beliefs can be tolerated so long as they occur within a background of mostly shared beliefs. Cath seems better able to adjust for the sub-optimal coherence than correspondence, which is against what Davidson expected. And the incoherence can be, at least partially, accounted for by a degree of self-deception: an awareness of illness motivating its denial and bolstering John's robust sense of self. Succour for the motivational hypothesis.

DENNETT & CONFABULATIONS

Confabulation is integral to Dennett's unified theory of mind and meaning. In the intentional stance an agent's perspective on her own actions action is the same as an observer's. She has no privileged access to her own motivations or beliefs so, according to Dennett, will produce "approximating confabulations" to account for her acts. Thus, confabulation is actually describes all our claims to self-knowledge. In Dennett's famous multiple-drafts vision of consciousness a multitude of mini-*selves* constantly produce competing narratives, only one of which enters conscious awareness. The narrative is not selected or composed consciously, nor does it arise from an illusory single cohesive *self*; yet it sustains that illusion.

> The agent comes to label its tendencies *as if* they were governed by explicitly represented goals – blueprints for actions – instead of trends of action that emerge from the interplay of the various candidates… Their effect on any audience is to encourage them to (try to) posit a unified agent whose words they are, about whom they are: in short, to posit a *centre of narrative gravity*.[73]

"Pathological confabulation is unwitting fiction of an entirely different order,"[74] however. Described as "verbiage" that "sounds virtually normal… so natural and 'sincere' are the reminiscences and the ready answers to questions," pathological confabulation exposes this inherent propensity for self-narration. The confabulations are entirely interpretable; the person who utters them certainly means what he says and they may be rather revealing of his personality and concerns. But for Dennett pathological confabulations are epistemically dubious as they are neither justified nor true. It is difficult to conclude whether confabulations are meaningful or not from the intentional stance. On the one hand, they are psychologically revealing, but epistemically irrational on the other. Given that for Dennett meaning and rationality travel together, it is unclear what sense he would make of John's pathological confabulations.

DOES JOHN BELIEVE AND DESIRE WHAT HE OUGHT?

"*And yesterday I was out where she worked, and she said, 'You can come and live with me' and so I said, 'Thanks very much,' and I can get to get my money to pay her you know*." (270)

John denies being in hospital, doesn't seem to know he already lives with his sister, and makes erroneous claims about his recent past. Cath also recognises such failings: "*He doesn't even know that he is in the London hospital. You can ask him and he will say 'Yes,' but a few minutes after he will say, 'No.'*" (294) He clearly does not believe what he ought about his environment. In her efforts to understand why he says what he does, Cath refers to events in his past life as a potential source: "*A ship that sank and he got saved… which I think is the Titanic it is in his mind, you know him thinking it's the Titanic […] I can't say that it hasn't happened, because I haven't been in England as long as him you know.*" (293) Nevertheless, she denies that his claim someone was shot to death on the ward can be so explained, musing: "*Now where did he get that from in the hospital?*" (307) Cath attempts to reduce the disparity between what she thinks John ought to believe and what he claims to by confronting him with his epistemic errors. She quizzes and questions him in the hope that he will notice the improbability of his claims and their poor justification. John, while recognising their implausibility, cannot be persuaded to revise his beliefs. The identification of such false beliefs is, for Cath, intuitive and pre-reflexive. She need not pause to reflect, and her laugh reveals the implausibility for her of thinking otherwise. "*I am sure it is not [laughs], I know that is not true [laughs]*" (297) "*[W]ell I thought it is not true, you can't think that is true.*" (300) John is not wrong about everything he ought to believe but if one produced a catalogue of the beliefs he should hold given his "perceptual capacities, epistemic needs, and biography,"[75] it would tally poorly with his explicit statements. John's desires do, however, seem to accord with what he ought to want. "*I don't want to stay there [unidentified lodgings] long, I want to go to my sisters*." "*I don't know what the situation is but he [HCA], he, me and him had an argument out at the house and I said, 'I want to go home.'*" (274) He wants to be well, at home with his family, honest and trustworthy. This agrees with what we know of his earlier life as an industrious family man. The first assumption that underpins interpretation, therefore, fails to hold for beliefs but not obviously so with regard to desires. This raises the prospect of John's beliefs, desires, and actions being misaligned, indicting his rationality.

IS JOHN IRRATIONAL?

During the interview John is frequently expresses statements that are mutually inconsistent: he claims to be ill and perfectly healthy; he both has and has not seen Cath recently; at one moment accepting then refuting that he is in hospital; and he is even inconsistent on the

trustworthiness of his "*stories*." "*I suppose they think that I'm making it up, may be at times I do, I don't know, that is another thing, I don't, I don't think I do […] no, as I say I am not that type of person, I tell the truth and if something happens I tell it.*" (284) A construal of this inconsistency is self-deception. This folk psychological concept[76] preserves the surface meaning of his statements while also attributing a complex mental attitude: aversion to truth. It does not eliminate the inconsistency but recognises in his repudiations a motivation to avoid unwelcome truths: "*to be quite honest I forget half the things that happen, 'cos if I didn't I would go fucking mental [laughs] honestly, but I am not, I mean… I went for a head test… and the doctor said that they found nothing… so I am supposed to be bloody mental and I know that I am not mental.*" (271) Consistency is achieved, therefore, not through re-ascription of belief/desire but by hypothesising dynamic processes that augments folk psychology in a manner amenable to Dennett. Correspondingly, Cath regards John as wilfully inhabiting a "*different world*" that protects him from painful reality: "*He would rather be in the world that he is in 'cos that world is right, he thinks that world is right for him*." (308) At other points, she admits to not understanding him at all: "*Well he doesn't say sensible things [laughs]... he used to, not now.*" But this may be a consequence of disrupted interpersonal communication while attributing to John a reasonably coherent and cohesive worldview of his own: "*Because you can't get inside their mind, inside their brain to know these things. Only they know...*" (298)

DO OTHERS ADOPT THE PHYSICAL STANCE TOWARDS JOHN'S CONFABULATIONS?

Although Cath struggles to understand all John's stories, she does not simply switch to the physical stance; she grasps for psychological and physical level explanations simultaneously. Asked whether she thinks his altered behaviour and talk relate to the psychological (unresolved grief) or biological (dementia) factors she had identified, Cath replies, "*It is both, it is both.*" (296) However, interpretative difficulties recognised from the intentional stance were confirmed subsequently by the CT head scan. "*Yeah, when I found out he was in hospital and they done this scan on his head, I knew that he wasn't quite well then, he was lapsing*." (304) Cath does not revoke personhood from John and she insists he be treated with dignity, his preferences respected, and he is encouraged to remain independent. She does, however, talk as though he has regressed to childhood and is desirous his roving be curtailed, his autonomy clipped.

According to Dennett, confabulations are false-narratives that reveal something of their creator's personality. They defy intentional stance ascription and prediction while exposing the multitude of "semi-independent semi-intelligences" that compete to narrate on-going action. Their epistemic shortcomings demonstrate they are imperfect narratives yet still have a story to tell.

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DISCUSSION

INTRODUCTION

Turning to the final discussion there are a number of issues to be addressed. The most important is, of course, has the main study question been answered? This, it will be recalled, can be summarised thus: Does meaning falter or fail in neuropsychiatric symptoms? This will be tackled in the section that immediately follows and naturally leads on to discussions about the relevance for, first neuropsychiatry as a sub-speciality, then considering the same question for psychiatry as a whole. The discussion ends with reflections on the success or otherwise of mixed methodology research – combining philosophical and empirical approaches – and whether this kind of study has a future.

DOES MEANING FALTER OR FAIL IN NEUROPSYCHIATRIC SYMPTOMS?

Let us consider these in reverse order. Does meaning fail in neuropsychiatric symptoms; that is, are they meaningless. The answer would appear to be a resounding no! There are three considerations that justify this response. The first concerns the overall coherence of the patients' statements. Although each revealed a sub-optimally coherent belief structure none demonstrated flagrant negation of the sort that Davidson claimed undermines interpretation and even the assumption one is dealing with a "thinking creature."[1] The inconsistency was worse than Dennett's fictional lemonade seller,[2] but resembled the "cognitive dissonance" [3] he sometimes says is permissible and had been anticipated by Davidson. Just as the latter proposed that beliefs could be caused by mental states that are not their reason,[4] the carers, and perhaps the reader, posited emotional states and unconscious desires as *ad hoc* conjectures that optimized coherence, vouchsafing a degree of meaning. Dennett, however, may consider this a "gratuitous and incautious overextension of the realm of the intentional."[5] But frank inconsistency tended to be eradicated by hypothesizing these folk psychological type mechanisms; the sort of "parochial" [6] refinements that become inductively learned, which he intermittently sanctioned. The most pessimistic predictions made about what happens when meaning fails did not happen. Dennett advocates a drop to the physical stance, which while entertained is not a move that was decisively made by the carers. They prevaricated and appeared to simultaneously

embrace both intentional and physical type explanations. Similarly, rationality and autonomy were not revoked wholesale and the patients continued to act by-and-large in accordance with those around them. There was preservation of too much complementary behaviour to warrant the most cynical predictions of non-personhood or an incommensurable "form of life." Secondly, Wittgenstein's discussion on dreams and hallucinations points to an inherent tendency to interpretation. Even where the apparently inexplicable is encountered this tendency drives humans to offer a narrative explanation. For instance, Kahneman describes "narrative fantasies" [7] whereby a coherent story is produced in preference to admitting ignorance of complexity. The greater the ignorance, the better the story that must be told: "Yes, of course, it must be like that,"[8] as Wittgenstein said of Freudian interpretations. The parallel here is obvious; it could be argued that participants produced meaningful narratives that just mask their shortcomings just as Nisbett & Wilson[9] demonstrated how subjectively unaware we are of the processes underpinning belief and the like in their famous paper. In the renowned supermarket-stocking test described in the *Introduction*, one is aware of which pair of stockings was chosen but the decision-making process is opaque. Nevertheless, a narrative is offered – "these ones felt nicest" – while explanations in terms of subconscious processes were explicitly refuted. Why is this a reason for supposing meaning does not fail completely? Because it shows that there is continuity here with non-pathological processes and we would not wish to say of the stocking-choosers or Kahneman's subjects that what they say is meaningless. If we prohibit it in the psychopathological cases, then it should be universally prohibited. Also, the overt tendency to find reason explanations for the unusual experiences and utterances will in itself reveal concerns and preoccupations of patient and carer respectively. That is, even if their narrative explanation for the neuropsychiatric phenomena is wrong it is nevertheless of relevance and illuminating. This accords with the phenomenologists' view that every insult, whether psychological or organic, invokes a personally meaningful response[10] and brings us to the final reason for concluding that meaning does not fail completely in neuropsychiatric symptoms. The IPA methodology seems to recover a great deal that is coherent and comprehensible when the patients are viewed in the round. Each analysis disclosed themes such as fear of disintegration, death, and incipient madness. Identities were being questioned and sanctuary sought. The actual content of symptoms was linked, at least tentatively, to significant life events from the distant past. Connections were made and evaluated even if the process and outcomes was less than perfect. Many of the themes strike one as appropriate to the patients' circumstances and an overlap with the carers' own

interpretations can be discerned. Both Dave and Jane recognised a long-standing fear of rejection and abandonment in his Capgras' delusion while grief and loneliness was explicitly recognised by Cath and emerged in the IPA analysis of John's confabulations. The symptom's meaning was not totally obscure to any of them even as it was not fully transparent. Interviewing patients about their symptoms was a novel experience for the author. It is usual practice to explore a symptom just long enough to sketch its contours and define its features for the purpose of diagnosis. Clinicians tend not to dwell on the personal significance of neuropsychiatric symptoms hence spending an hour discussing nothing else felt shockingly new. And there was a great deal more sense and coherence than the standard mental state examination uncovers. Recall Jaspers worry the un-understandable might be overextended through the clinician's own limitations: "it is a matter of his human stature as to what he understands and how far his understanding reaches."[11] While the human predisposition to interpret finds meaning everywhere, clinicians view the symptoms through the prism of their own theories, which is itself a system of interpretation. It may be clinicians cannot but perceive a symptom as meaningless if they stick too rigidly to their models, thereby ignoring the meaning that is there. This supports Jaspers' view that the empathic/understanding approach must be actively chosen and pursued. In light of the above then, we conclude that meaning does not fail in neuropsychiatric symptoms, but does it falter? Here the answer must be in the affirmative and is supported by two lines of reasoning.

To begin, the carer interviews clearly reveal that there is no difficulty appreciating that something is wrong. That is, the problematic communication and behaviour was readily apparent to the layperson just as it is to the clinician. This accords with the finding that laypeople are highly adept at identifying the presence of mental disorder even if they fail to correctly classify the condition.[12] Neither Cath nor Jane required coaxing or explanation to pinpoint the psychopathological terrain of interest – they understood there was a problem even as they attempted to make sense of it. This stood out precisely because they had trouble knowing exactly what the patients' claims amounted to, whereas non-problematic communication remained invisible, so to speak. This, recall, is true for both psychological and neurobiological models of psychopathology; each agrees that *something* is in want of explanation. As with theoretical models, the carers reach for a special story that involves extra-conscious entities to account for the odd utterance. This IPA finding concurs with

recent work by Nick Haslam on "folk psychiatry"; the study of how people come to regard others as mentally disordered.[13] When laypeople "pathologise"[§] behaviour it is then attributed to one of three potential causes: moral, medical, or psychological. Haslam argues that judging behaviour to be pathological involves at least four elements: i) infrequently encountered behaviour is by definition unfamiliar, hence puzzling; ii) pathologising occurs where it is difficult for an observer to provide a coherent explanation for particular acts, iii) a behaviour that is deemed unusual or distinctive tends to be attributed internally to the person. Such an attribution is reinforced where the behaviour is stable across contexts; and iv) finally, groups that are considered small (minority) yet held to share common (and threatening) characteristics are regarded as distinct entities so more readily pathologised. In Haslam's model, while pathologising opens up an explanatory gap that needs to be filled, it need not necessarily indicate mental disorder. Behaviour that contravenes social norms can be viewed as *morally* reprehensible, remaining the responsibility of the person so behaving. *Medicalising* on the other hand attributes the behaviour to abnormality caused by a disease, hence outside the person's control. Haslam describes a third explanatory style – *psychologising* – that lies between the moralising and medicalising poles: "To psychologize abnormality is to make sense of it using psychological concepts that have causal rather than intentional force."[14] These explanations invoke mechanistic and functional concepts (e.g. absence of Theory of Mind in psychopathic disregard for others); challenge the principle that actors are aware of their own reasons/motivations; involve causal histories that incorporate psychological factors, such as the actor's personality traits and psychosocial development; and appeal to emotions and their physical correlates. This partly causal story of which the actor is only partially aware is unique to psychological explanations and marks it as distinct from fully "intentional" accounts and medical explanations, which exclusively involve biological causation. It is also what we see with our cases. The carers blend knowledge of a disease process with details from the personal history, unconscious motivations, and unacknowledged desires to make best sense of their loved one. Meaning falters but does not fail. It falters for all to see, hence comprehension's "shock… in the face of"[15] psychopathology, but retains a degree of continuity with premorbid characteristics and intentionality. How the identification is made comprises our second reason for the conclusion that meaning does falter.

[§] Haslam confusingly uses the term "pathologise" to refer to all seemingly abnormal or norm-breaking behaviour, whether attributable to disease or not.

Liz, John, and Dave all held beliefs about their immediate environment and, to a lesser degree, non-perceptual beliefs that Dennett would say they ought not hold. But he also allows special stories such as hallucination and imperfect memory to salvage our ability to interpret; so intentional stance interpretation is not fatally undermined by these false-beliefs, which are, in any case, held alongside a store of accurate ones. This component of the intentional stance is similar to Davidson's principle of correspondence and Wittgenstein's agreement in judgment. A shared culture, evolutionary history and neurobiological structure license an interpreter's assumption that others concur with her own beliefs about the environment. This assumption failed in our cases. The carers were disconcerted by what they perceived as false beliefs about fundamental matters, such as this being a hospital and that being and inanimate doll. There were no restorative special stories or re-descriptions to be told. Similarly, agreement in judgment means to broadly agree about the truth or falsity of a large number statements about the shared world – "this is a hand" etc.; exactly the type of statements being disputed. And this cut both ways. The patients, including Liz, were as frustrated as the carers. All three found the discrepancy between their basic perceptual experiences and those of others hard to bear. They spoke of anger, distress, distrust, rejection, and self-doubt: each one mooting the possibility of mental disorder only to rebuff it. The patients' most disputed judgments concerned ordinary states of affairs like those listed by Moore as being beyond doubt. Each symptom could be said to contravene a personal, local, or universal hinge belief, to some degree, with the patient accepting as true what others regard as impossible and, moreover, now doubting what others hold to be certain. Rhodes & Gipps[16] have argued that delusions represent a disruption to hinge beliefs, accounting for why they are bizarre in content, conspicuous to others, impervious to counterargument, and held with certainty.[**] Considering the features in turn, each of the cases do report some highly implausible beliefs and these vagaries are obvious to carers and reader alike. Cath and Jane described as futile their efforts to establish a reason for John and Dave's false-beliefs. Patients and carers could not agree on what even counted as evidence. Nonetheless, surely the most important feature is whether the patients act on these beliefs with certainty, whether they provide a new foundation. But it would appear that they do not. The patients express doubts, misgivings, and inconsistent responses. Relatedly, patients with insight for their psychotic symptoms are known to

[**] They have never argued that hinge beliefs are implicated in confabulations or hallucinations, it should be noted.

experience lower moods[17] and score higher on scales measuring self-deception[18] than those without awareness. But this is not the collapse into uncertainty anticipated by Wittgenstein. They also continued to act in the world and evidently, despite the disputed statements, agreed on much else besides.

The above discussion shows that poor coherence could be mitigated to a large degree but disagreements about perceptual beliefs could not. Nevertheless, these are not so severe as to undermine all meaning and communication given there is so much agreement in other matters, which echoes Bolton's claim that there is often more meaning and sense than initially supposed.[19] Indeed, this concord enables us to appreciate the transgressions that were made by the patients.

WHAT DOES THIS MEAN FOR NEUROPSYCHIATRY?

Confabulation, visual hallucination, and, to a lesser extent, Capgras' delusion are considered paradigmatic neuropsychiatric symptoms.[20] When present they are strongly suggestive of neurological disease. Even here, however, we find that meaning is implicated in the expression of the symptom; they do not conform to the picture of the myoclonic jerk described in the introductory chapter, a reminder that clinicians must attend to the meaning and personal significance disclosed during the consultation. It is not, however, always so easy to do in practice. For instance, when first reviewing Dave's transcript his preoccupation with death emerged as obvious and insistent yet was disconcertingly unheeded during the interview. The dialogue reads as clumsy and insensitive. Early on Dave disclosed, "*When you come towards the end and even if it is just a basic thing, you get to the end itself, it's a panic, I don't know that for sure now*, *but I can see it for definite*, *on earth things did not go well, there is only one other way to go and that is to go even worse than what you have now*." (216) This solemn confession provoked the inapt response: "*Right, and what is going on for you now that is difficult*?" (216) A pressing need to get on with the business of the interview led to a salient theme for Dave going unnoticed. This may point to a personal failing of the author or a more systematic failure in our approach to patients. The neuropsychiatrist should pause, as the author was forced to do in these interviews, to reflect on what is really being said rather than treat the mental state examination as a checklist of signs for the

purpose of diagnosis. Patients want their psychiatrist to acknowledge and address the content and personal significance of symptoms[21] while adept communication improves their satisfaction and outcomes.[22] The sensitive clinician might also endorse provisional interpretations proposed by carers, which could reduce carer burden, enhance empathy, and support effective communication. Furthermore, it is known that predominantly biological models of mental disorder are more stigmatizing and alienating than psychosocial explanations.[23, 24] Efforts to augment continuity and coherence with the patient's lived experiences will mitigate overly medicalising attributions and improve understanding.[25]

The inescapable role of meaning in the clinical encounter is mirrored in neuropsychiatric theorizing about symptoms. Recall that each type of model broached meaning, explicitly or implicitly. An example of an implicit role for meaning can be seen in Coltheart *et al's*[26] model for the formation and maintenance of Capgras' delusion. The first stage involves the patient developing a highly specific perceptual deficit then reasoning, using perfectly adequate Bayesian inferences, that his or her partner must be an imposter. Both the perceptual deficit and reasoning occur outwith conscious awareness. Coltheart *et al's* Bayesian calculations are based on two rival hypotheses for the altered perceptual experience: "that person is my wife" and "that person is an imposter." While restricting the competition to two hypotheses simplifies the maths it multiplies the questions. Why only two and why these two? Why not hypothesise, "she must be wearing a different perfume" or "I feel odd today." Personal history surely has a bearing on the hypotheses someone, even subconsciously, generates to account for an altered experience. Further, there is reason to doubt the perceptual deficit and subsequent inferences are quite as constrained as the cognitive neuropsychiatrists allege. Capgras' original description of *Mme M*[27] involved an entire Police department, the doctors and nurses caring for her, and many more besides. Dave could acknowledge some vague change in Jane's comportment - "*when I did find Jane, Jane didn't look like Jane, Jane looked like this Jane*" (217) – but also spoke of experiences quite at odds with the neurocognitive account: "*there were a few others that looked like Jane, there is even a lad there that looks like Jane*." (222) There is also nothing Bayesian, however, about the second stage[28] which, they argue, explains the maintenance of the delusion rather than its rejection: "the second factor is a failure of the system whose job it is to consider new evidence of this type so as to revise current beliefs."[29] The failure is conceived as yet another cognitive deficit that endorses the delusional content despite its being inconsistent with other beliefs and in

the face of arguments to the contrary. The deficit is inferred because the delusion is incoherent and irrational, which brings us to the same terrain as the discussions on meaningfulness above. Yet there was more coherence and rationality than their model allows.

Recall too the phenomenological approach to Capgras' delusion.[30] Phenomenologists maintain that there is a great deal of meaning in the delusion's content if only we look hard enough, but they also posit an anomalous experience of which the sufferer is trying to make best sense though do not tell us wherefore the anomaly arose. The phenomenological and neuropsychological models are composed of a meaningless causal part and an additional element. The cognitive neuropsychiatrists infer a further deficit from what they perceive as too much incoherence – too little meaning – while the phenomenologists repudiate the deficit account for inverse reasons. We might call them "deficit plus" models for they add a meaningful stratum over and above the neuropsychological impairment. The phenomenologists such as Radcliffe say that standard folk psychological reasoning is adequate to get from anomalous experience to delusion. Dave though would seem to belie that assertion. There is something we do not quite get; but it is not sufficient to undermine meaning completely. On the other hand, a commonsensical approach to interpreting him does get one quite far. There is little need for the tortuous philosophically inspired interpretations Sass proposes that alienate as they explain and amount to a hermeneutics of suspicion.[31] The same situation pertains for models of confabulation. Source monitoring deficits and failures of strategic retrieval are hypothesised as explanatory causes and the content dismissed as inappropriate and inconsistent with other utterances and behaviour. Indeed it is the "purposeless," "incidental and unmotivated," and "unintentionally incongruous"[32] nature of the confabulations that enables them to be identified as such. It is reasonable to ask Gilboa and Moscovitch why particular memories evoke a strong "feeling of rightness"[33] when others do not. Is this chance also? If the content is mere accident how to account for the continuity and appropriateness of the themes revealed in the analysis of John's confabulations? Fotopoulou for her part finds a great deal of coherence in confabulations that function to preserve identity and self-esteem in the face of illness and impairment.[34] John too demonstrates the disadvantageous loss of accord with others that accompanies this strategy, illustrating that meaning falters but does not fail completely. This all implies that neuropsychiatric theorising should not expunge meaning from its models

even where a deficit is included. There just seems to be too great a role for meaning for it to be excluded *prima facia*. If later down the line the incoherence and discord in judgment are found to be overwhelming then by all means a purely causal model can be pursued. But the situation that currently pertains of discounting and excluding meaning from the outset cannot be advocated.

None of these results should be particularly surprising. Clinical reasoning in neuropsychiatry frequently invokes concepts that are replete with meaning. Take conversion disorder, which has not been included in this study but is a common presentation to neuropsychiatrists.[35] While there are positive physical markers of conversion disorders, such as Hoover's sign in the identification of functional leg weakness,[36] these are neither fully reliable nor available for the whole gamut of conversion symptoms. Instead, clinicians utilise psychological and moral concepts such as deception, psycho-trauma, and distress as part of the diagnostic and explanatory framework for this range of disorders[37] while the manner in which symptoms present reflect, "reasonable lay beliefs about brain function."[38] Also, the neuropsychiatric assessment involves objective investigations such as neuroimaging, blood tests, and neuropsychology to a greater degree than other psychiatric sub-specialities but the relationship between the test findings and mental disorder is not simply reductive. Take a patient with psychological symptoms following traumatic brain injury. While an MRI neither conclusively proves nor disproves neurological aetiology, the results do enter into diagnostic reasoning. But such clinical judgements are based on whether the behaviour correlates with the severity and site of the lesion; its relation to the patient's psychosocial context; and the patient's premorbid personality and functioning. Lishman, for instance, described a 50-year-old man who suffered a mild head injury but developed memory impairment suggesting "organic brain damage."[39] Ultimately it was concluded a depressive disorder had developed following the accident and that "his wife had colluded and reinforced this aspect of the situation." In other words, reasons and motivations were invoked that excluded neurological injury as an explanation. The point is not that reason-type explanations took primacy over physical investigations, or *vice versa*, but rather to show that the former are implicit in clinical decision-making even though their character remains relatively obscure. Meaning it seems is endemic to the clinical encounter, neuropsychiatric models of symptoms, and in clinical reasoning. These reflections will hopefully serve to undermine Jaspers' pessimistic opinions on the meaning and interpretability of symptoms in "organic cerebral disease,"

which, it will be recalled, was "as if an axe had demolished a piece of clockwork – and crude destructions are of relatively little interest."[40] Far from being of relatively little interest the finding of meaning in paradigmatic neuropsychiatric symptoms has relevance for psychiatry as a whole.

WHAT DOES THIS MEAN FOR PSYCHIATRY?

So if we find meaning in neuropsychiatry does this imply it is ubiquitous throughout psychiatry? The short answer of course must be yes. Finding meaning in the statements of neuropsychiatric patients suggests this will be true of the claims made by all patients with mental disorders. Note though that the study was intentionally restricted to symptoms that are assessable directly through language. It cannot be inferred that each and every psychiatric or neuropsychiatric symptom can be conceived as meaningful. Apathy, fatigue, disinhibition and other, in Jaspers terminology, "objective" manifestations of mental disorder may not be amenable to interpretation. But it is likely that all symptoms accessed through language are to some degree meaningful given the patient will always be disclosing these through the prism of self-interpretation, which is never theory-neutral. The study may also be informative with regards neurological symptoms. Even sophisticated psychiatrists such as Jaspers and Arthur Kleinman[41] assumed that the symptoms in so-called "organic" psychiatric disorder conveyed little if any meaning. Jaspers in the quote above was unflatteringly contrasting psychiatric symptoms of neurological disorder to those found in the rest of psychiatry. "Organic" conditions were reckoned to sit between psychiatry and neurology, marking the boundary between the two fields. This is based on a false opposition of the two domains, which has been questioned for some time[42] with increasing empirical justification. Neurological and psychiatric disorders share similarities both in terms of gross structural changes in the brain[43] and social determinants.[44] The manifest meaning in neuropsychiatric symptoms suggests there may be more meaning in classical neurological symptoms than has been supposed. It is the case, however, that neurological symptoms are largely accessed through direct physical examination, so the pool of potentially meaningful symptoms is smaller.

Just as meaning is a poor marker of the boundary between neurology and psychiatry it similarly cannot function as the limit between illness and normality that some have hoped. To see this, recollect the arguments in *The Loss of Sadness*[45] about whether a mildly depressed mood is best considered an illness or a psychological reaction to adversity. A lowered mood can be conceived in terms of recent loses and a tendency to withdraw from conflict, a neurotransmitter deficit, or faulty information processing. This amounts to the difference between finding the condition a normal response to adversity or a disorder, say Horowitz and Wakefield. They advise that discriminating between these depends on whether one can find an "appropriate reason"[46] for the depressed mood. But this is an empty claim. For one, we know that patients and carers have a tendency towards coherent narratives so will cast about for reasons for an event, even where there is none. This exemplifies the well-known recall bias that confounds research in the social sciences where a respondent actively searches for meaning. It is near impossible to tell the difference between *a* reason for a mental state and *the* reason, especially where, as is the case for aetiological factors in mental disorder, the event may precede the condition by many years. Second, even in the neuropsychiatric symptoms we found enough meaning and connection with life events to speculate these may have a role in the construction of the symptom. Their phrase "appropriate reason" just cannot bear the weight placed upon it. They could point to the deficit component found in each of the models discussed as lacking an appropriate reason. But it should not be supposed that all psychiatric symptoms will be best accounted for by the "deficit plus" type model. Relatedly, the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*[47] proposes that a pattern of psychological/behavioural phenomena cannot be considered a mental disorder if it is an expectable response to stress or loss. While frequency of response is cited, there is no mention of specific rates implying it is clinicians' intuitions about how people should respond that carries the load. This again shows that failure to identify reasons for psychological phenomena is implicated in the attribution of mental disorders. As meaning is found wherever one looks in psychiatry, it become impossible to defend boundaries based on the absence of meaning.

As meaning falters but does not fail in psychiatry we can now question whether it is sufficiently addressed in both clinical practice and research. Clinicians reportedly value formulation with its emphasis on personal meaning, individuality, conflicts, and motivations but lament the lack of time and training necessary to go beyond "reductive" diagnoses.[48]

Indeed, there is widespread dissatisfaction with the current "technologizing" of the profession that views psychiatry as simply a form of neuroscience.[49] While this study did not examine formulation the findings accord with these concerns. Being forced to engage with the significance of symptoms for both patient and carer enabled the author to perceive more sense and meaning than had hitherto been expected. This is not identical with the assessment of insight and illness belief because these primarily appraise the patient's agreement with a medical interpretation of their presentation. Nonetheless, it would be a good point in the mental state examination to ask about the patient and carer's own interpretation of the symptoms. This may improve engagement and expose concordant and discordant views, which could be addressed directly and assist mutual comprehension. In the longer term, this may have positive impact upon carer burden and the negative consequences[50] that go along with it. Admittedly, this is speculative but feeling listened to and understood is associated with better engagement and outcomes.[46] Likewise, there is increasing realization that the meaning and significance of life events for patients needs to be included in research studies. The famous Caspi *et al* study demonstrated an interaction between life events and polymorphisms of the serotonin transporter gene has been associated with depressive disorder and neuroticism, a personality trait that predisposes the individual to depression.[51] Whether the association turns out to be valid or not it shows that simplistic genetic determinism is now being challenged as a research method in psychiatry. The fusing of life events, psychological theorizing, and neuroimaging is most evident in modern research on conversion disorder, a classic neuropsychiatric condition and considered by Freud the paradigmatic mental disorder. The recent handbook *Functional Neurological Disorders*[52] is a good illustration: life events, illness beliefs, personality traits, and functional neuroimaging are all covered. However, these advances involve a denuded conception of meaning. They fail to include patient and carer's subjective appraisals and necessarily enumerate life events and personal factors. Is it in fact possible to conduct research in psychiatry that retains a non-reductive conception of meaning? This brings us to the final section of this discussion.

REFLECTIONS ON IPA AND MIXED METHODS RESEARCH

It has been emphasized repeatedly that the present study involved a non-standard use of IPA; there has been far greater emphasis on the secondary analyses than the primary, the

converse of usual practice where the subjects' challenging experiences take centre stage. Nevertheless, the relationship between the primary and secondary analyses requires some discussion, given the empirical, albeit qualitative, nature of the former while the latter is conceptual. Findings from the primary analyses have been deployed to argue for the continuance of meaning in the symptoms studied. Is this line of reasoning legitimate? Firstly, the carers' subjective experience of attempting to understand their loved one does sit comfortably within the IPA sphere. Unfortunately we were restricted to just two carers, both of whom, nevertheless, reported difficulty understanding specific aspects of the patient's utterances and behaviour, providing some limited support for the study aims. Cath for instance said, "*there is no sense in what he says in this last while whatsoever.*" (302) Frustrated at being told by professionals just to agree with whatever John is saying, she questions the basis of his claims, "*cos I want to know, to get him trying, to get him back*." (303) These quotes indicate the theme "Bringing back from error" in Cath's interview which itself echoes "There is no interpretation" in Jane's: "*I think that he is just sort of talking out loud*." (239) Thus, the primary analysis provides encouragement for further inquiry; carers experience difficulties with interpretation. The originators of IPA recommend presenting the two types of analysis separately, as here, so the reader can see the different results for herself.[53] The problem is whether the primary analysis has any traction on the secondary. IPA was designed to identify and expound meaningful interpretations whereas this study was explicitly concerned with whether meaning falters or fails in neuropsychiatric symptoms. It is not obvious that an analytic method based in the phenomenological and hermeneutic tradition has a role to play in the investigation of meaning in psychopathology? Or, as Wittgenstein would have said, "problems and methods pass one another by."[54] This very pessimistic reading is moderated by the similarity in the results obtained by the two types of analysis. Yes, the primary analysis does search after meaning and, lo-and-behold, found a great deal of it in the patient and carer interviews. But the secondary analysis aimed to explore its nature; it sought to understand whether the ascriptions of content were justified, according to the theories of meaning. The general finding that the neuropsychiatric symptoms were not quite so beyond the pale of interpretation from the formal theories of meaning as has sometimes been alleged (e.g. Jennifer Radden's *On Delusion*[55]) vindicates the finding of meaning in the primary analyses. Conversely, the themes that emerged in the latter contributed to our discovering enough coherence and rationality for the formal theories. The primary and secondary analyses are thus mutually validating. There are a

number of practical and exegetical hazards that may undermine this sanguine conclusion, however.

For one, there are insufficient interviews from which to draw reliable conclusions. IPA is a qualitative methodology that venerates depth of analysis over quantity and given the complexity of studying meaningfulness in psychopathology it seemed prudent to err on the side of quality over quantity. Nevertheless, this opens the study to the criticism that the cases are un-representative or, worse, misleadingly selective. Certainly, the difficulty locating English-speaking neuropsychiatric cases with minimal cognitive impairment and the richness of the interviews suggests exceptional individuals. However, they were recruited sequentially over a few months without further selection and none stood out to the author as different in kind from those seen in routine clinical work. Another problem is a lack of homogeneity in the sample, as required for IPA. It could be argued that all interviewees should be experiencing confabulations, for instance, rather than patients with a diverse range of symptoms plus their carers. While this might be more methodologically true to IPA it would also obscure what is of greatest interest: what unites the meaningfulness of these neuropsychiatric symptoms and do patients and carers understand them? Another practical consideration is that as a relative newcomer to IPA the primary analyses may be inadequate. Smith *et al* have observed that novices tend to be overly conservative in their interpretations while experience enables richer and more sophisticated interpretations. This is less of an issue here because even a conservative analyst discovered enough meaning to buttress the interpretations made in the secondary analyses. The ubiquity of mortality as a theme in the interviews could be taken as evidence that the results have been unduly biased by a preoccupation of the author rather than a true reflection of the participants' experiences. It is certainly correct that IPA is susceptible to bias as all interpretations are founded in theory. However, it is not surprising that this theme emerged so frequently. The participants were all relatively old and so quite naturally were beginning to contemplate their own demise. Illness is always a bodily threat that raises the possibility of death or loss of identity. Indeed, death is an unending metaphor for loss of various kinds, such as the spiritual decay of *Death in Venice*. Appendix F contains the first five pages of the annotated interview and it clearly shows how Dave's opening sentences communicate an acknowledgement and fear of death: "*well I am here for, er, it's an illness a funny illness, well not funny but frightening, has passed a lot of stuff through my mind of what is going to*

happen, how it is going to happen and hopefully in the end it might be a better, for the want of a better word, finish." (216) Finally, the exegeses of the philosophers' respective theories are not incontestable. Each philosophical position has generated a substantial secondary literature and counter-arguments that have been largely ignored. While Dennett and Davidson have been able to answer their critics, and such papers have been utilised in the explications above, the interpretation of Wittgenstein is a parlous task. His writing is rather cryptic in form and he was known to accuse commentators of misrepresenting and contradicting his unpublished work,[56] which constitutes the vast majority. As such, each "theory" has been presented with textual support from the primary sources; clarity of exposition has been prioritised over philosophical dispute; and interpretative errors are attributable solely to the author, not the legion of proponents and critics of each philosopher.

Despite these efforts it is ultimately unclear whether philosophical accounts of meaning can satisfactorily be brought to bear on the clinical phenomena. The components of each theory are so entwined that it felt awkward to examine them in isolation yet also impossible to apply as a whole. There has been nothing to suggest a productive research programme will emerge, as can sometimes be the case when Dennett hurls testable hypotheses to his colleagues in the neurosciences.[57] The aim of articulating exactly how meaning falters has been sadly elusive. Pointing to a problem with correspondence, agreement, and such like is similar to Jaspers' early and vague notion of empathy that has recently been updated.[58] But this shifts rather than clarifies the problem. Nevertheless, taking the time to listen sincerely to what patients say is not always evident in psychiatric practice or research so has been a welcome liberation for the author. Reticence notwithstanding, it is to be hoped that one can glimpse the contours of Jonathan Glover's own conclusions:

> Psychiatric disorder can make people in some ways radically strange without obliterating all the human psychology they share with others… Seeing things from apparently incompatible standpoints gives a metaphor for psychiatry as a whole… We need the external scientific theory. And the view from inside, interpreted with empathy but also with searching questions.[59]

Future research in this area could usefully focus on the carers and their attempts to understand those with mental disorder, of all types. IPA can be commended as a robust and replicable method for examining lived experience from a (relatively) neutral perspective. So much work on insight and illness beliefs seems concerned with bending subjects to the worldview of the clinician that listening to the carers' interpretations would serve as useful corrective. Ultimately, work on interpreting patients by carers should begin to address carer burden and whether optimising shared understanding can ameliorate the worst consequences for patient and carer. Fotopoulou has already taken the first steps in methods that seek to restore meaning to confabulations. Again, she may wish to supplement these studies with those utilising IPA methodology, elaborating the descriptions of content beyond their emotional valence.

CONCLUSIONS

Meaning in neuropsychiatric symptoms does falter but does not fail. Exactly how it falters is harder to specify but incoherence appears less problematic than difficulty with intersubjective agreement, whatever that means exactly. Although the study could not give a clear and unambiguous answer, the conclusions presented do offer a vindication of the study aims and the autonomy of the mental justifies developing appropriate methods of investigation distinct from their neural correlates. Exactly how to study this is however less clear. All we can conclude is that the meaning of neuropsychiatric symptoms is untold.

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APPENDICES

A. Information leaflets

B. Consent forms

C. Patient semi-structured questionnaire

D. Carer semi-structured questionnaire

E. Ethics approval letter

F. Dave's annotated IPA transcript

G. Dave's transcribed interview

H. Jane's transcribed interview

I. Liz's transcribed interview

J. John's transcribed interview

K. Cath's transcribed interview

Patient Information Sheet

Understanding psychological symptoms

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. We'd suggest this should take about 20 minutes. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Ask us if there is anything that is not clear.

The study involves being interviewed on one or more occasions (maximum three times) by Dr Norman Poole, consultant psychiatrist.

What is the purpose of the study?

The study seeks to explore how patients and their carers understand psychological symptoms caused by changes in the brain. Sometimes these symptoms can be difficult for others to understand and we want to know why. Hopefully this research will make it easier for professionals and carers to know why patients with changes to the brain do and say what they do.

This research is being conducted by Dr Poole as part of his Medical Doctorate degree. This is an advanced research degree for medical doctors.

Why have I been invited?

You have been approached because you have a psychological symptom as a result of change in the brain caused by illness. A few patients with similar symptoms and/ or their carers are being asked to take part in this research.

Do I have to take part?

It is up to you to decide to join the study. Deciding not to participate will not affect the standard of care you receive. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

If you agree to be part of this study Dr Poole will interview you about your symptoms. Interviews will be conducted in the Department of Psychological Medicine at the Royal London Hospital. The interview will take up to one hour. If more information is needed, Dr Poole may want to interview you again. You will not be interviewed more than three times. You can choose to be interviewed alone or in the company of a friend or carer.

The interview will be recorded on an electronic dictaphone. Dr Poole will later write up the interview. The audio files and written interviews will be kept on a password-protected computer in the hospital. Only Dr Poole will have access to these files. Some words and phrases you say might be included in the final Doctoral thesis. However, this will be fully anonymised meaning you and your family cannot be identified by anyone who reads it.

Being involved in the research will not affect your treatment in any way. If you do not wish to be involved in the research your treatment and care will also not be affected.

Once the interviews have been completed your part in the research will come to an end. After this, you will not be asked to do anything more.

How many people will be part of this research?

We expect up to six patients and six carers will be recruited into the research study.

Will I be paid for taking part?

We cannot pay any fees or expenses but we can arrange for a taxi to bring you to and from the hospital for the interview.

What will I have to do?

All you need to do is talk with Dr Poole about your experience of living with psychological symptoms caused by changes in the way the brain works. In particular, Dr Poole will be interested in how you make sense of the symptoms. You will not be expected to do anything else as part of the research.

The symptoms of interest can improve quite quickly so it will be important to attend for an interview as soon as practical after you have agreed to take part in the study.

Participants in the research will be expected to attend the interviews on time and stay for up to one hour. There could be a maximum of three interviews. Once sufficient

information has been gathered Dr Poole will end the interview. Dr Poole will inform you when your involvement in the research is finished.

What are the possible disadvantages and risks of taking part?

Sometimes talking about psychological symptoms can be upsetting. Dr Poole is an experienced psychiatrist who has interviewed many patients and carers over the course of his career. If he notices that you are becoming distressed the interview can be stopped for a brief period or rearranged for another day. Alternatively, you can choose to withdraw from the research completely. This will not affect the care you receive from our services.

Interviews about patients' and carers' experiences are often conducted as part of research. The vast majority of participants do not find it distressing or upsetting.

Attending an interview for up to one hour can be inconvenient. We will arrange the interviews to be as convenient for you and your family as possible.

What are the possible benefits of taking part?

People who participate in research often find it of benefit. Talking about your experiences of living with psychological symptoms can help you to understand them better.

We cannot promise the study will help you but the results of this study may help improve the care people with psychological symptoms caused by changes in the brain receive in the future.

What if there is a problem?

If information becomes available that we think is relevant to your continued participation in the research we will inform you of this as soon as practically possible.

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Could I be asked to leave the study?

If the research interviews are very distressing to you then your involvement in the research should end. Dr Poole will advise you if this is his recommendation

If the symptoms and experiences of interest to the research have resolved then your involvement in the research will come to an end. Dr Poole will tell you if this happens.

Care after the research ends

Your involvement in the research ends after the interview(s) have been completed. You will no longer need to be seen by the research team. Involvement in the research will not affect your future treatment or care.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

If you want to withdraw from the study you are free to do so. The care you receive from services will not be affected in any way.

Dr Poole may still wish to use some of the information you have provided as part of his research. This will remain anonymous, so you cannot be identified. If you do not wish any of the information you have provided in the research to be used then it will all be destroyed.

What if there is a problem?

Complaints

If you have a concern about any aspect of this study, you should ask to speak to Dr Poole who will do their best to answer your questions [Dr Poole is available on 020 3594 6695]. If you remain unhappy and wish to complain formally, you can do this through the East London NHS Foundation Trust's Patient Advice and Liaison Service (PALS). You can call them freephone on 0800 085 8354 or by writing to Consumer Relations, FREEPOST RLSH-BBHX-ZRRU, Trust Headquarters, EastONE, 22 Commercial St., London E1 6LP.

Harm

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the sponsor, King’s College London. However, you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital/surgery will have your name and address removed so that you cannot be recognised.

Confidentiality can in certain exceptional circumstances be broken. When, for instance, the research team think someone might be hurt. If so, we will talk to you first about the best thing to do.

The interview(s) will be recorded onto a digital dictaphone. The audio file will be uploaded onto a password protected East London NHS Foundation Trust computer. The original audio file will then be destroyed. Only Dr Poole will have access to the password. No one other than Dr Poole will have access to identifiable information.

The audio files will be transcribed by Dr Poole. Identifying information will be removed so participants will be known by a code. All patient and carer identifiable information will be destroyed within 3 months of the completion of the research.

The handling of identifiable information will be in keeping with the Caldecott principles (see the Caldecott Report, Department of Health, 1997).

Involvement of the General Practitioner/Family doctor (GP)

It will not be necessary to inform your GP of your involvement in this research.

What will happen to the results of the research study?

The study is mainly being conducted as part of Dr Poole's Doctoral research. The results of the research will be written up as part of the Doctoral thesis. Some of the results may be published in research papers for relevant medical journals. No identifiable information will be published in either the thesis or research papers. Papers and the final completed thesis will be made available to study participants, if requested.

Who is organising and funding the research?

The research is not being funded by a charity, pharmaceutical company or academic institution. East London NHS Foundation Trust will cover the cost of taxis, where necessary. Dr Poole is self-funding the Medical Doctorate.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NHS Health Research Authority NRES Committee London – Queen Square and the Research and Development Office at South London and the Maudsley NHS Foundation Trust.

Further information and contact details

General information about research.

More information about research at East London NHS Foundation Trust can be viewed here:

http://www.eastlondon.nhs.uk/Research/Research.aspx

Specific information about this research project.

Please contact Dr Norman Poole on 020 3564 6695 or email norman.poole@eastlondon.nhs.uk for further information on this research study.

Advice on whether to participate.

Please talk this over with someone who knows you well. Alternatively, you may wish to discuss it with a health professional involved in your care.

Who should I approach if I'm unhappy with the study?

In the first instance contact Dr Norman Poole. Alternatively, or if you are unhappy with the response you receive, you can contact East London NHS Foundation Trust's Patient Advice and Liaison Service on 0800 085 8354 or by writing to Consumer Relations, FREEPOST RLSH-BBHX-ZRRU, Trust Headquarters, EastONE, 22 Commercial St., London E1 6LP.

B. CONSENT FORM

Centre Number:

Study Number: UPS/P/001

Patient Identification Number for this study:

PATIENT CONSENT FORM

Title of Project: **UNDERSTANDING PSYCHOLOGICAL SYMPTOMS**

Name of Researcher: **DR NORMAN POOLE**

Please initial all boxes

1. I confirm that I have read and understand the Patient Information Sheet dated **24/12/2013** (version **2**) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I understand that the interviews will be digitally recorded. These recording will be transcribed verbatim then later destroyed. All identifiable information will be removed from the published research but anonymised verbatim quotes may be used. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

C. PATIENT QUESTIONNAIRE

IPA semi-structured interview for patients: version 2

1. Why you being seen at the hospital?

2. What is your understanding of the problem?

3. What do you think is happening?

4. When did you first notice a problem?
    a. What did you first notice?
    b. What was it like?
    c. How did you account for it?

5. What do the doctors say is the matter?

6. What do you think of their explanations?
    a. Do you understand their explanation?
    b. Do you believe them?
    c. Do you think it applies to you?

7. Do other people understand what you are telling them?
    a. Do they believe you?
    b. How does that feel?

8. Do other people understand what you are experiencing?
    a. Do you try to help them understand?
    b. What do you do to make them understand?
    c. Can you always make people understand?

9. When you say _____ do you mean just what you say?
    a. Do you mean those words in a different way from usual?
        i. In what way different?
        ii. Different from before? From other people?
    b. Is it like a metaphor?
    c. Are you trying to convey something that is difficult to describe?
    d. Do you want people to understand it just exactly as you say it?

10. Do these things relate to other experiences in your life or your past?
    a. What are they?
    b. How do they relate?
    c. Would other people understand this, do you think?
    d. Is there anyone in particular who would appreciate/ know this?
    e. Who and why would they know?

11. Do other people ever seem to not understand what you are saying?
    a. What is that like?
    b. Do you try to help them understand?
    c. Does this always work?

12. Do people ever seem to stop trying to listen to you?
    a. Do people ever seem to ignore what you are saying?
    b. What is that like?
    c. How does it make you feel?
    d. Do you understand why they do this?

13. Do people always respond to what you say?
    a. Do they respond how you want them to?
    b. Do they respond appropriately?

14. Are you unsure of anything now that previously you weren't?
    a. What? Why?
    b. Do you doubt things more now than you used to?

15. What do you understand of [TARGET SYMPTOM]?

16. What do you think about being interviewed about these things?
    a. Helpful?
    b. Upsetting?

D. CARER QUESTIONNAIRE

IPA semi-structured questionnaire with carers: version 3

1. Why is Mr/Mrs _____ being seen at the hospital?

2. What is your understanding of the problem?

3. What do you think is happening?

4. What is the doctors' understanding of the problem?

5. When did you first notice it?
    a. What did you first notice?

6. What did you think or feel at the time?

7. Did you understand what s/he meant?
    a. What do you think s/he means?
    b. Why do you think s/he says those things?
    c. Do you always know what s/he means?
    d. Does s/he ever explain what s/he means?
    e. What do you think of the explanations?

8. In what way is it hard to understand?
    a. What about what s/he says do you find difficult?
    b. Why is this difficult?
    c. What is it like to have a conversation about these things?

9. Do you do anything extra to try to understand what s/he means?

10. Do you have a way of understanding what is said?

11. Do you speak to anyone who knows him/her well to try to understand what is meant?

12. Do you think it is relevant to anything that has happened to him/her in the past?

13. Do you think s/he uses words differently now?
    a. From other people?
    b. From before?
    c. What is different?
    d. Do his/ her words mean different things than before?

14. Does s/he say anything that confuses or surprises you?
    a. What is said that makes you feel this way?
    b. What is that like?

15. Does s/he say things that don't seem logical to you?
    a. In what way are they illogical?
    b. How do you know they are not logical?

16. Could these things mean anything else?
    a. Do you have any other ways of understanding him/ her?

17. Do you always think s/he must mean something by what s/he says?

18. Do you always do your best to understand what s/he means?
    a. Is there more than one way to interpret what s/he says now?

19. Do you ever disagree with him/ her about how s/he sees the world?
    a. In what way?
    b. What is it that you disagree about?

20. Have you ever given up trying to understand what s/he means?
    a. Why?
    b. What was that like?
    c. Did it change how you think of him/ her?
    d. Did it change how you react or respond to him/ her?

21. Have these things changed what you think about other things s/he says?

22. How do you tell when things are easy or difficult to understand?

23. Do you think it is now harder to predict his/ her actions than before?

24. What do you think about being interviewed about these things?

E. ETHICS APPROVAL LETTER

NHS
Health Research Authority

NRES Committee London - Queen Square
HRA Head Office
Skipton House
80 London Road
London
SE1 6LH

Telephone:
Facsimile:

13 January 2014

Dr Norman Poole
Department of Psychology, Henry Wellcome Building
King's College London, Institute of Psychiatry
De Crespigny Park, London
SE5 8AF

Dear Dr Poole

Study title:	**Meaning and Meaninglessness in Neuropsychiatry: Understanding Psychological Symptoms**
REC reference:	**13/LO/1735**
IRAS project ID:	**123514**

Thank you for your letter of 02 January 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator at NRESCommittee.London-Westminster@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person

who lacks capacity to consent to taking part in the project.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		02 January 2014
Evidence of insurance or indemnity	RSA	01 August 2013
Interview Schedules/Topic Guides	Schedule for semi structured IPA interview	
Investigator CV	Norman Poole	23 October 2013
Other: Supervisor CV	Derek Bolton	12 January 2013
Other: CV Dr Michael D Kopelman	1	23 October 2013
Other: Personal Consultee Declaration Form - Adult	2	24 December 2013
Participant Consent Form: Patient	2	30 December 2013
Participant Consent Form: Carer	2	30 December 2013
Participant Consent Form: Personal Consultee Assent form - Adult	2	24 December 2013
Participant Information Sheet: Carer	1	23 October 2013
Participant Information Sheet: Consultee	1	23 October 2013
Participant Information Sheet: Carer	2	24 December 2013
Participant Information Sheet: Patient	2	24 December 2013
Participant Information Sheet: x		
Protocol	1	23 October 2013
REC application	123514/5182 38/1/573	24 October 2013
Response to Request for Further Information		02 January 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/LO/1735	**Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

Alison O'Kane

Dr Yogi Amin
Chair

Enclosures: "After ethical review – guidance for researchers

Copy to: *Mr Keith Brennan*
Jenney Liebscher, South London and Maudsley NHS Foundation Trust

F. DAVE'S ANNOTATED IPA TRANSCRIPT

pt001 **1/60**

Norman Poole Research

Key: **NP:** **Norman Poole**

Pt 001: Dave

Cr 001: Jane

Duration of interview: 58:47

Number of words: 8178

Number of pages: 60

Step 1 Initial noting: Highlights & Green notes

Step 2 Descriptive comments

Step 3 Phenomenological coding

Step 4 Interpretative coding

pt001 2/60

13	Phenomenological coding	Interview		Interpretative coding
		NP:	ok so I will just make a note here of the code, so you're Pt 001 and this is the first interview. Ok um now can you tell me in your own words why are you being seen in the hospital?	
	PROMPT: why in hospital?		emotional	
	illness: strange and frightening contemplating the future hope better end	Pt 001:	well I am here for er it's a illness a funny illness, well not funny but frightening, has passed a lot of stuff through my mind of what is going to happen, how it is going to happen and hopefully in the end it might be a better, for the want of a better word, finish	
			Fear, finality, death even.	
			emotional	
		NP:	finish, what, what	Prompt about being in hospital immediately brings him to subject of endings and uncertainty about how the illness will end
	end finish well, a conclusion	Pt 001:	finish. It is a difficult thing isn't it to sort of get something and try and wrap it up sort of	Seems to be aware of possibility of a difficult end to his life
			emotional, sound bite, vague	
		NP:	mmm huh	
			emotional	
	towards the end	Pt 001:	and when you come towards the end and even if it is just a basic thing	this is the beginning of the end?

pt001 3/60

	NP:	mmm huh (emotional)	
anxiety about the end	Pt 001:	you get to the end itself it's a panic, I don't know that for sure now (uncertainty)	
	NP:	mmm huh	Quite Heideggerian in that anxiety (angst) and death are linked - anxiety enables him to appreciate his finitude
he can see the end	Pt 001:	but I can see it (descriptive)	
	NP:	mmm huh (then certainty)	
certainty of this	Pt 001:	for definite	
	NP:	mmm huh (death again, life not going well) (idiosyncratic, sound bite)	
things going badly here on earth. alternative [to life?] is worse	Pt 001:	on earth things did not go well there is only one other way to go and that is to go even worse that what you have now	
	NP:	right, and what is going on for you now that is difficult	
fear and loss unsure what is being lost	Pt 001:	now, the horrible thing of, the fear of the losing your er what is the word, um losing (emotional) (irony) (vague)	the loss of his memory is like a death. loss of self and loss of personal identity has begun
	Cr 001:	your memory	

pt001 4/60

loss and fear contrasts with the past, what he once had, such as good memory [memories?]	Pt 001:	yes the loss of that which has happened to me now, but it is frightening, it is frightening because all the things I used to have, I used to have a fabulous, fabulous memory (emotional, repitition) (fear & loss)	
	NP:	mmm	
everything going right - great feeling competing with others this all in the past	Pt 001:	fabulous, I couldn't go wrong with anybody, anything, with any competition, I couldn't go wrong with it and it was a brilliant feeling when I was like that (emotional) (contrast to now, going wrong with other people)	vitality, virility, rectitude are things of the past
	NP:	mmm huh	
certainty and sureness in the past - could 'trust' himself	Pt 001:	when I was like that and they said so what do you think about that it was bap-bap-bap-bap and I couldn't go wrong at all (idiosyncratic, emotional)	everything now "wrong" and going wrong with others (awareness that he now IS going wrong with others
	NP:	mmm (descriptive, emotional)	
abilities in the past - now lost [implicit]	Pt 001:	going back to recording, singing, poetry, anything, I was so sharp	first instance where he talks of his prowess. Is he justifying himself to me? (as a fellow Scotsman)
	NP:	mmm huh	the artist?

pt001 5/60

death, ending, 10 year duration - [much longer than dementia]	Pt 001:	but it has died away in the last, it has got be 10 years at least	Ten years it has been dying, which is one year longer than his marriage. has his virility been affected for longer than his dementia been ongoing?
		emotional, descriptive	
	NP:	right	
		descriptive, emotional	
contrasting abilities now with past. infallible	Pt 001:	it has it has been that long, jigsaws and crosswords and things like that	
		I was absolutely hot when it came to those	
		repetition for emphasise. first thing he brings up is loss of memory and ?death	
	NP:	mmm	
abilities gone. can't cope with this	Pt 001:	but it has all gone, all gone and that is the one thing that I can't handle,	
constant concern		really I can't handle, it comes to my mind all the time	
		emotional, sound bite	
	NP:	so is that the worst thing for you?	
infallible, able now gone occurred gradually without his realising	Pt 001:	yeah because I had it all, it was all up there, I had it all and it is gone,	
		the thing is it didn't just go it crept up on me	
		emotional, descriptive	
	NP:	mmm huh	
		presence and absence	
objective 'it' external to himself and sense of agency 'it' took away memory	Pt 001:	and it, it let me know that it was there and something was happening	presence and loss again
		and this thing was taking away my memory	something else did this to him
		emotional, descriptive	powerlessness

G. DAVE'S TRANSCRIBED INTERVIEW

NP: ok so I will just make a note here of the code, so you're Dave and this is the first interview. Ok um now can you tell me in your own words why are you being seen in the hospital?

Dave: well I am here for er it's a illness a funny illness, well not funny but frightening, has passed a lot of stuff through my mind of what is going to happen, how it is going to happen and hopefully in the end it might be a better, for the want of a better word, finish

NP: finish, what, what

Dave: finish. It is a difficult thing isn't it to sort of get something and try and wrap it up sort of

NP: mmm huh

Dave: and when you come towards the end and even if it is just a basic thing

NP: mmm huh

Dave: you get to the end itself it's a panic, I don't know that for sure now

NP: mmm huh

Dave: but I can see it

NP: mmm huh

Dave: for definite

NP: mmm huh

Dave: on earth things did not go well there is only one other way to go and that is to go even worse that what you have now

NP: right, and what is going on for you now that is difficult

Dave: now, the horrible thing of, the fear of the losing your er what is the word, um losing

Jane: your memory

Dave: yes the loss of that which has happened to me now, but it is frightening, it is frightening because all the things I used to have, I used to have a fabulous, fabulous memory

NP: mmm

Dave: fabulous, I couldn't go wrong with anybody, anything, with any competition, I couldn't go wrong with it and it was a brilliant feeling when I was like that

NP: mmm huh

Dave: when I was like that and they said so what do you think about that it was bap-bap-bap-bap and I couldn't go wrong at all

NP: mmm

Dave: going back to recording, singing, poetry, anything, I was so sharp

NP: mmm huh

Dave: but it has died away in the last, it has got be 10 years at least

NP: right

Dave: it has it has been that long, jigsaws and crosswords and things like that I was absolutely hot when it came to those

NP: mmm

Dave: but it has all gone, all gone and that is the one thing that I can't handle, really I can't handle, it comes to my mind all the time

NP: so is that the worst thing for you?

Dave: yeah because I had it all, it was all up there, I had it all and it is gone, the thing is it didn't just go it crept up on me

NP: mmm huh

Dave: and it, it let me know that it was there and something was happening and this thing was taking away my memory

NP: mmm huh

Dave: I knew it was, but I just couldn't fight back against it because it just wasn't there

NP: and what did it feel like, when you said it crept up what was that like?

Dave: it was case of when it was creeping up like that, it was stopping, and thinking to yourself, why is doing this and how is it capable

NP: mmm huh

Dave: because it won't let me do anything, it is crushing me and it was awful

NP: mmm

Dave: and it still is awful, I can't stand the bloody thing

NP: Professor Kopelman told me that you had, had some worrying thoughts about your wife, is that correct?

Dave: my, my wife of the moment?

NP: er yeah I think so, sorry I am not, because I haven't spoken to him directly because he has been away, but my understanding is that you worried that your wife had been replaced by somebody, that your wife wasn't who she said she was

Dave: umm

Jane: you did have this thing about there being 6 or 7 Jane's, the last 2 days thank God; believe it or not it has been reasonably good

NP: mmm

Jane: you know when I said to you that I am Jane your wife and you say to me don't be stupid where is my wife? Can you

Dave: of yes, that is very, very recent

Jane: yeah that is what he said

Dave: when I um

NP: can you tell me a bit about?

Dave: of the recent stuff?

NP: the recent thing with

Dave: um we were all together weren't we for some reason or another or we got together and then we sort of moved about didn't we?

Jane see I don't know when you are asking him, should I just leave him and let him

NP: yeah I will try

Jane yeah

Dave: um Jane was in the, it wasn't an association or anything, it was just a thing where we all seemed to get together in various, not various places they were in houses and things like that, but it wasn't alcohol or other stuff

NP: mmm

Dave: we don't do anything like that and just things um there was a lot of these people especially the women, I look at Jane and um Jane would disappear

NP: mmm huh

Dave: and another girl would come along and I had a chat to her and bap-bap-bap and I know that Jane was over there somewhere and I would talk to the girl and would be getting on well but when it came to looking for Jane, I couldn't find the, Jane and when I did find Jane, Jane didn't look like Jane, Jane looked like this Jane and that sort of thing

NP: mmm

Dave: and then when Jane came back it was just something that wasn't the same

NP: when did this happen?

Dave: this was about what 6 months ago?

Jane yeah

Dave: something like that

Jane yeah it has been going on since

Dave: it is as recent as 6 months

NP: so what about at home, was Jane at home with you or was it somebody else?

Dave: um no, no Jane and I have always been together

NP: mmm huh

Dave: it would never be someone else

Jane but what would happen is and it still happens when we are at home, we could be sitting and watching TV or whatever

NP: mmm huh

Jane and then he would say to me so where has everybody gone and I would say there wasn't anybody else here only you and I

NP: mmm huh

Jane no, no, no the 2 girls that were doing whatever and I would say I don't know where they've gone

NP: right

Jane so then he would say to me right and I would say I am going to get the dinner and I would go into the kitchen and he would come into the kitchen and say to me I wonder where Jane my wife is, I haven't seen her for 3 or 4 days and I would say to him, um he would say to me I will have to go and look for her or whatever and I would say no, no, no I am Jane your wife

NP: mmm huh

Jane and he would go no you're not so then we start, he would say why won't you tell me about the people that have been here and just left

NP: mmm

Jane and I would say I don't know

NP: mmm

Jane rather than say they weren't actually here

NP: mmm

Jane we tried that and that didn't work, we tried pretending ok they were here and I don't know who they are and that's when he would say um that he is going

NP: yes, yes

Jane so it gets us into a state

NP: so would you ever look at Jane, your wife, and think that is not my wife that is somebody else

Dave: not as clean cut as that, say that is my wife there but it is not my wife, no, no not that

NP: ok could you describe what it was like

Dave: er if it is someone because umm it is quite um

Jane you said that we all looked the same

Dave: yes you did, exactly you all looked although you were part of a family, I mean who had come from 14 year old to 16, 18 year olds, but you all had the same faces

NP: mmm

Dave: that sort of thing

NP: mmm

Dave: and that is what used to protect me is I know that's not Jane, because she is too short, I know that's not Jane because her hair is dark, but not as dark as Jane's

NP: mmm

Dave: I would figure it out from there and whittle it down to that is Jane there

NP: and were you always right when you whittled it down?

Dave: no I don't think I was, I think

Jane you only started to whittle it down over the last couple of days really haven't you?

Dave: yeah that's right

NP: and can you remember what it was like before the last couple of days when you, when it really felt like you were unsure who Jane was?

Dave: yes these other girls who were there, they were not Jane's family, I didn't see any of the family

NP: mmm

Dave: but they all looked like Jane

NP: mmm

Dave: so the others I was just meeting them, they would go away and I would go and look for Jane and Jane wasn't there

NP: mmm

Dave: and I managed to get hold of a group of them, say 4 or 5 of the women, as I was calling them, 4 or 5 of them and go through them all and say where's Jane, I cant see her, where is she, did you see her last? and they would say we are not this and we are not that

NP: mmm

Dave: and er Jane what Jane and they would and I would start to boil a bit and start to a panic

NP: mmm

Dave: sort of thing and I didn't know what to do, walking out and then walking in again and then walking out again and going home because I didn't um and it was getting um not nice

NP: what is your understanding of what has been going on, of this thing all around Jane not so much to do with the memory but more about with Jane? What is your understanding?

Dave: I don't, I just don't know, it was as though something was going on, but I couldn't imagine them doing anything, you know sort of, um I don't know um together. I never tried to get any knowledge from one of them, the other one would stand beside her and they would look at each another and sort of um, yeah yeah yeah, blah-blah and leave me there and it would make me feel sort of not quite there

NP: what do you think was happening?

Dave: for one, I wasn't panicking as much as trying to sort out what was going on with these people?

NP: mmm

Dave: because they were just sort of ordinary people and I couldn't work it out not for a long, long time, I couldn't work it out, you know why are they treating me like this, why? Why won't they tell me, are they hiding something from me, what? Is there something going on?

NP: and what do you think is causing you to feel this way?

Dave: I don't know, it could be things in my brain perhaps that were pushing me another way, perhaps, as far as Jane was concerned I think I was getting worried, really worried and I was panicking and I was afraid, I was afraid I was going to lose Jane

NP: did you think your worry about losing Jane is what caused you to have these experiences, is that what you are saying?

Dave: to begin with, no I don't think so, I suppose most men go into, go through something like this, they must do, otherwise they're, they're not right. I just don't know it was a terrible, terrible, terrible experience, I mean really bad because it made me cry and it made me, I wanted Jane, I wanted her with me I couldn't bear the thought of her not being there or if she just turned on her heels and walked away from me and all that sort of stuff

NP: mmm huh

Dave: and I was panicked and I just didn't know where, who, how, what

NP: mmm, when did you first notice the problem, not with the memory but with Jane and worrying about Jane?

Dave: nothing really, we have been together for how long?

Jane [laughs] 11 years

NP: what I mean, with these experiences going on for the last 6 months, what was the first thing you noticed, when did you first get an inkling that you were having these troubles?

Dave: there must a been a little something previous to that, that might have been going on in my head and maybe, and I am sure this happens with everyone, maybe Jane could be having other thoughts about her life you know with her husband and stuff like that and I probably thought to myself suppose Jane is thinking along those lines what would I do? And eventually it probably worked its way like a worm in my head and took over and I did have a time like that when I was worried and sick about Jane

NP: so it began with you worried that Jane would leave you and why did you worry that she would leave you, why would she do that?

Dave: I don't know, she is a good few… 12 years younger than I am

Jane 16

Dave: well

Jane but I told you that I wouldn't let you off that easy darling, so you don't have to worry about that

Dave: yes

Jane Dave has always been a very insecure person

NP: mmm

Jane and I think that probably goes back even before your 1st wife love, definitely when you split up with your 1st wife it hit you so badly

Dave: sorry

Jane sorry you have to keep telling me to stop cos I am dreadful when I get going [laughs]

NP: sorry Dave, yeah so the first thing you noticed was a worry that Jane might leave you

Dave: mmm yeah and of course there is a loneliness even before anything happened and it didn't happen, but there was such a loneliness that was bearing down on you, awful, I didn't um running away I was, I didn't want to go near it, I would have given anything to just have cleared the whole thing out of my mind and wake up and Jane, it was all over and Jane was gone and everything

NP: mmm

Dave: basically as long as I wouldn't have been in the condition I would have been in, that sort of thing

NP: did you ever become convinced that Jane had left you?

Dave: no, I have great confidence in Jane [laughs]

NP: mmm

Dave: always have had

NP: how do you account for the worry that Jane is going to leave you, what is that based on?

Dave: um it could be about what Jane was talking about when my wife split with me and took my two girls um two girls away and I lost it a bit there and had to go and see one them um lads you know, that look after you

NP: mmm

Dave: [laughs] didn't last long with him [laughs] sorry. Yeah that was my life and thinking that you are never going to be with another woman seriously again, I was going to wash my hands of my wife but it took me so long to get over it and the girls, it was awful, it was awful especially the girls. After a while it's the wife first, if you put your wife then the children will be there and it didn't work like that and I am quite convinced that she did the dirty on me and made certain moves that would carry up beyond me and into a new life and I was stuck with the same one, by myself

NP: and do you feel that that experience

Dave: could have
NP: definitely or?
Dave: yeah I would say definitely I would say because she stayed with me for quite some time but only in my head.
NP: could you describe what you mean by that a bit more, do, do you mean that the two of you were together but only in your head was it really a relationship
Dave: um no, she cut it straight
NP: right
Dave: and that was that, so even if she saw me in the street or the like
NP: so what way was it still there in your head
Dave: I could not get over the truth that she had left, she had left me and I had a feeling that she was going out and about, you know, that sort of thing because I knew that she was going to clubs and things but she must have had someone looking after children, and I knew that was going on so I didn't know, I didn't know where to go.
NP: have the doctors, has Professor Kopelman explained what he thinks is happening, why you are having these experiences?
Dave: what now?
NP: mmm huh the ones with Jane and worrying about Jane
Dave: um I don't think he, um maybe, he did make a few, pass a few sort of little remarks and things and then said do you think, and talking the way you are now and said quietly and nicely Andrew do you think that Jane, and of course you take it all in
NP: what did you think of his explanations?
Dave: his explanations, well there must have been reasons why my wife left but I think the answer was that I wasn't a very go-get guy, you know I had all the customers I needed, you know for a decorator and I didn't need to ask for work it was given to me, um, that is about it, um, it was just who I was
NP: so did Professor Kopelman explain why he thinks you are having these experiences and fears?
Dave: that I am having now?
NP: mmm
Dave: no I think that I am a lot stronger now really
NP: mmm
Dave: I am still afraid of it happening and going in to a panic and all that sort of thing
NP: did he say anything about the changes in your brain explaining these experiences?
Dave: I think he did, in fact I am sure he did [laughs] yes
NP: can you remember what he said?
Dave: um he did push me through something like that, now let me think, yes I think he did, he thought it was the other thing, the forget thing, yes
NP: mmm huh so he linked it in with that
Dave: yes he did
NP: what did you think about that as an explanation?
Dave: I didn't um [laughs] taking it in and thinking there is nothing wrong with my head, it's alright, I've got a great head and that I know that for sure
NP: mmm
Dave: but then he explained a few things to me and he never mentioned what's it called um the disease?
Jane um dementia
Dave: dementia, he never sort of mentioned that, open
NP: mmm
Dave: but I think what he did do was he left it to the end of what we were involved in

NP: mmm
Dave: you know with the Professor, is he a Professor?
NP: mmm
Dave: yeah in between that and what was it he said um it's gone, you see this it's left, its run away.
NP: can you remember if you believed his explanation?
Dave: no but I got what he was saying, his explanation yes I did, and I believed it because he told me that and he is a very genuine man
NP: mmm
Dave: and during the course of when I saw the other chap he was of a step higher doesn't he, does he?
NP: I am not sure who you have seen
Dave: Gelder
Jane I think Professor Kopelman is the highest one isn't he
Dave: yes
Jane and Dr Gelder works with him
Dave: well through the two of them and the school of them who are there, the group on the day
Jane yeah the team
Dave: it was my final um day
NP: yeah
Dave: and the big lad he started talking about, but nobody had mentioned dementia here before, but it is connected with…
NP: do you think that you are seeing lots of other people as Jane, is that is connected to Dementia?
Dave: no I don't think so, no I don't think so
NP: and your worrying that Jane has left you and you can't find her, is that connected to the Dementia?
Dave: yes because I knew she was there, but sometimes it wasn't memory because this person looked like Jane
NP: mmm huh
Dave: and there were a few others that looked like Jane
NP: mmm huh
Dave: there is even a lad there that looks like Jane
NP: so when you see these other people who look like Jane do you think that that is part of the dementia?
Dave: you mean the dementia that I have?
NP: correct
Dave: well it means that I had it then, doesn't it, it must mean that I had dementia then which I didn't know anything about
NP: so that would be 6 months ago when it first started?
Dave: yeah
NP: that's what you mean?
Dave: but previous to that when Mr, you know the big lad
NP: yeah
Dave: the guvnor I think isn't he?
NP: the guvnor [laughs]
Dave: yeah when we got together to sort of, when we got to the end to go through it and have a chat about it between the two of them, he was the one that mentioned, you know he said you're a great lad he said for your age aren't you, you know what I mean. How old was I then?
Jane 69, you had your first memory test about two years ago wasn't it
Dave: well he gave me a bollocking for looking so well [laughs] that sort of thing, but he got round to the dementia thing and he said don't worry he said you haven't got dementia, you don't have dementia
NP: mmm
Dave: that is what he said

Jane so you're not losing your mind

Dave: blah blah blah and things like that so I was just happy to let that go

NP: so do you think, um I am unclear at the moment as to whether you think the dementia, the dementia and the way it effects the brain is why you were seeing other people as if they were Jane or is there a different explanation

Dave: can you give me that again?

NP: yeah, do you think that your worries about seeing other people as Jane, is that caused by the dementia or something else?

Dave: the thing is I took the memory thing, that is my you know, biggest ordeal

NP: mmm

Dave: the memory thing, the dementia to me is just something that happens to people

NP: mmm

Dave: even when someone says to me well it's a sickness, you know once I heard that I had it, it's a sickness, and it's an illness. I thought it's not an illness for God's sake an illness is when something they give you makes you alright but it's all mixed up together, the memory thing I would sooner go for that than the dementia thing

NP: yeah, so do you think that the worrying that other people look like Jane is that connected with the memory problem

Dave: no, I would say I would say definitely not

NP: when you told people about Jane and Jane not being there and other people looking like Jane, did people understand what you were saying to them?

Dave: um in some cases yes and in other cases no, because they were looking at me sort of funny, because of me sort of going up to them and saying um where is Jane? where is Jane gone? and I haven't seen her. Of course you have seen her; you were standing there beside her talking to her, what is this, did you see her at all, no I didn't see her. And then it got worse because then I got angry because Jane wasn't where I thought she was, I didn't know where she was

NP: right

Dave: that sort of thing and I knew I wasn't going to see her that night, I didn't think I was going to see her at all

NP: mmm what is it like when you say these things to people and they don't seem to understand?

Dave: that to me, that sort of thing gives you the feeling of not being all there, and that makes you really angry because you can't get the words out that you want to say, it won't come out. You feel as though you are definitely a no-no with them, a nothing, because you are going around asking people and they are looking at you know, as though somebody is passing on to someone else, and then you ask them and there no replies, you know go away we don't know who you are talking about get on your way, and there was about 4 or 5 of them but the… woman and whatever they can vanish when they go to the toilet and stuff like that, before you know where you are 2 or 3 of them have gone together and gone and it comes down to Jane.

NP: do you think people tried to understand what you were talking about?

Dave: no this is what got me. They weren't giving anything; they weren't saying anything, like I say they were looking at me, you know, like he's not there

NP: why do you think they were looking at you in that way?

Dave: I don't know, they were just looking at me saying like, for God's sake who is he? who is he? and I knew myself that they were doing that but they knew that I knew them, but they are making it look as though I don't really know them at all

Jane that's what annoyed you because they wouldn't tell you what you wanted to know

Dave: they wouldn't say anything, they were just turning their back on me

NP: do you think that people understood what you were experiencing?

Dave: mmmm, I don't know but I know something for sure they weren't worrying and they weren't caring

NP: did you do anything to try and help them understand what you were experiencing?

Dave: oh yes

NP: what did you do?

Dave: you know going up to them and saying, look for God's sake you're hurting me, I want to know where they went, I can't move from here until I know where they have gone and they go yeah blah-blah-blah and do that sort of thing

NP: do you think you could, you could have made people understand

Dave: I did, I really did do my best I was trying to talk to them they wouldn't, they just treated me like an imbecile. Like, what is he doing? I wasn't overdressed or underdressed or any other way, it was just what I got from them.

NP: do you think you could have made them understand, what could you have done to make them understand?

Dave: nothing, because I couldn't do anymore than I had done to make them understand and I am still trying to do

NP: was the difficulty with them understanding or with you sort of communicating?

Dave: I would say communicating because I wanted at least for them to take that sort of scornful look off their face when they were sort of telling me to go somewhere else, yeah that wasn't good.

NP: when you say that people looked exactly like Jane or just like Jane, do you mean that exactly as it sounds that they looked exactly like Jane?

Dave: yes

NP: did you mean it in a sort of metaphorical way it was as, if you like, as if they were like Jane?

Dave: I didn't think of it like that, I took it as looking like them trying to talk to them but in my head at the same time the fact that they did look like Jane, they more or less spoke in the same kind of manner as these other people spoke, like Jane did and things like that

NP: so when you went up to these people to speak to them you believed you were talking with Jane?

Dave: I did until I got there, and then realised it wasn't her

NP: and what, what did you do then?

Dave: I asked them again oh come on you must know where she has gone

NP: so once you realised they weren't Jane you would ask them where Jane is?

Dave: exactly

NP: and why would they know where Jane is?

Dave: because Jane had been speaking to them throughout the amount of time they had all spent together because she knew them all and there were people moving in and out and going away and coming back and then going away again

NP: you mean in and out your house?

Dave: mmm

NP: when you had said Jane had gone away, did you mean that in a metaphorical way or that she had actually gone?

Dave: I thought then that that's what had happened, that Jane had skipped… you know… and when that had happened, I realised that Jane wasn't there so then that s when I started looking for Jane and start walking

around to the group, and realisation was that Jane had skipped off with someone else, not male

NP: mmm huh

Dave: that's what I thought.

NP: when you were talking about these experiences with people were you using words in just the usual way the way that you would normally do?

Dave: no, when after asking several of them after a time you start getting a bit more, you know, you start losing it slightly and you are talking like that then, how do they expect me to, you know, to you when you are getting no return from you, and just, there was nothing there

NP: when you were talking to people about these experiences were you, were you trying to, were you using words in a different way from how you would normally use them, did they have a special meaning or a special?

Dave: no

NP: there was nothing different about your use of words?

Dave: no

NP: were you trying to convey something, a very difficult to describe experience and the words weren't just quite up to it?

Dave: [pause] um, I don't think so no.

NP: so when you were describing these things to the people you wanted them to understand it exactly as you were saying it?

Dave: um, I was hoping, I would just ask a question and be told I saw her go round the corner with a lover or something

NP: mmm do these experiences relate to anything else that has happened in your life or in the past?

Dave: um, no I don't think, so only the desertion thing, that's all.

NP: mmm this seeing people looking just like Jane does that relate to anything that has happened in the past?

Dave: um, no, because I didn't know Jane back then [laughs]

NP: I mean the experiences, I suppose, it does need to you know, it is just a question

Dave: um, no there wasn't anything in my real early, early years that I know, no, I had a good mother and I had brothers and sisters, we didn't have anything mind you, we didn't have any goody goodies or any money or whatever , but I did well in school mind you but couldn't carry on

NP: it seems to me to be almost two aspects to the experience almost on the one hand it's a fear that Jane has left you and on the other hand it is seeing other people looking like they are Jane

Dave: mmm

NP: is that correct?

Dave: um

NP: have I understood it correctly?

Dave: yes, they weren't absolutely Jane, but the features and the actions of the face, that was Jane, with these other girls and one lad I think. He even looked like her.

NP: mmm did you have the same sort of emotional response as you do when you see Jane?

Dave: I always have the same emotional response when I see Jane

NP: what is that?

Dave: I love Jane and it is great to see her.

NP: and when you saw all these people, did it feel like that

Dave: yeah, but not for the same values as Jane could give me when I saw her

NP: so is it slightly different to when you see Jane and it is the real Jane, could you describe that?

Dave: yeah it is as though if I could have got any understanding from any of the others that were there whom I was sort of hunting, now Jane, is just is Jane there and that is all I wanted, nothing else

NP: did it ever feel that um people weren't listening to you?
Dave: mmm, they just sort of turned their head away and just moved away
NP: did you ever understand why they did that?
Dave: I suppose it was because I was going around and maybe, but I don't recall at any time being a nuisance to any of them. I got replies, I do know some of the replies, they weren't being nasty or anything like that
NP: did people always respond to what you said?
Dave: no not really, they were the type that were turning their heads or walking a few strides ahead or stopping and carrying on their little or things like that.
NP: do you think they were reacting to what you said though by walking away was that it?
Dave: yes, they were just being what they were; they were just blocking me out
NP: so they weren't reacting to the way that you wanted them to react?
Dave: no
NP: how would you have liked them to react?
Dave: I thought that if they had watched and saw whatever I was doing, sort of walking around trying to get Jane, anybody who had saw me walking around like that would have felt a bit of um you know, I have lost the word
NP: sympathy?
Dave: mmm yeah sympathy, there is even a stronger word than that [laughs]
Jane compassion?
Dave: no compassion is a similar thing anyway that, that you know that sort of feeling
NP: you would have liked people to respond with some kind of compassion?
Dave: yeah
NP: I don't want to put words in your mouth, is pity the word that you were looking for?
Dave: no… apathy
NP: so you would have liked them to respond with some apathy? or empathy?
Dave: empathy.
NP: empathy, what would that have looked like, what would that have involved them doing?
Dave: well sort of you know, sort of giving up some sort of, same thing, give the bloke a chance or something like that, a silly thing, but it is not the sort of thing I could do, I couldn't watch somebody going through that particular thing, it is not nice
NP: what would have been the right response?
Dave: well if it was truthful, [laughs] oh yeah Dave she went straight through there and she has got Sylvia with her. you know something straightforward, you know
NP: mmm
Dave: but no, Jane was gone.
NP: but it sounds like some of the things you were saying to them confused them, perhaps?
Dave: I don't think so, I don't think so, and it has been done as a, I don't know how to describe it, they always seem to be eager, they come along with the sane answers.
Jane you said it was like a conspiracy
Dave: yeah, mmm
NP: and do you think they all knew where Jane was?
Dave: what they all knew was that Jane had left the premises
NP: so they knew that and they understood why you were asking?

Dave: yeah I am sure they did, because they were asking because they all understood that Jane had walked out or gone out

NP: so it sounds like, the questions them you were asking them, they understood perfectly

Dave: I think so

NP: did they understand why you were asking the questions?

Dave: I am sure that they did, either that or it is down to Jane again I am afraid, if like um people say in this sort of situation, they go [whistles] gone

NP: they were trying to keep Jane from you

Dave: they were trying to keep me from Jane because I don't think that um Jane wanted anything to do with me that time, that night

NP: why would she not want anything to do with you then?

Dave: um I don't know maybe boredom, liked what she was doing, having a few drinks, laughing with the girls and all that sort of stuff and then one lonely cowboy and it's a panic then for him and it is awful

NP: some people have called this um what we call a Misidentification Syndrome, have you heard that term?

Dave: yes

NP: what do you think of that?

Dave: since then I can see some truth in it

NP: since when?

Dave: since a few, there have been quite a few, of what we are all thinking, it is just, I don't know I have lost the trace, the trace then of what you have asked me

NP: um some people have called this a Misidentification Syndrome and I am just wondering what you think of that, whether you think that it is a syndrome that occurs in illness

Dave: um well it wouldn't always be in illness, would it?

NP: that is the idea, yes, that is what, that is what sort of doctors think, if you like, about it

Dave: mmm

NP: what do you think?

Dave: I don't think there is anything else, is there, I mean you were saying that is what doctors and what they think

NP: does that change things if doctors think that of it?

Dave: well yes it backs up whatever it is and whatever the others are thinking, whether you are thinking that or not

NP: what are you thinking now?

Dave: I don't know, I really honestly don't know

NP: what do you understand of the term Misidentification Syndrome, if you have heard it?

Dave: I have heard it, is that, that, it is um in the book isn't it?

Jane: the book Professor Kopelman gave us, um a guide to living with Dementia or something

Dave: yes that is it

NP: yeah

Dave: mmm huh; no I haven't read it [laughs]

Jane: well we have read it together

Dave: Jane too yes

NP: did you think that there was a ring of truth to that?

Dave: um er yes, it is because, in a case like this, when you start reading it and you develop a piece of it again and again you start to think oh yes, oh yes, you do um you do think um

NP: mmm

Dave: that is what you do and plus you carry on with anything else you can get your hands on [laughs]

NP: is it helpful to read those books and to have that kind of an explanation there?

Dave: I suppose it is, yes, but I haven't um I stopped the reading a long, long, long, long, long time ago

NP: has it helped you having it explained in those terms?

Dave: I liked reading it and then having to read it again to understand what I am reading about

NP: mmm huh, do you think that it applied to you in your case?

Dave: I don't think um [laughs] if it means do I think that I am um ill, well I must believe it

NP: you must believe it?

Dave: yeah that I am ill

NP: so you must believe that, that explanation is that what you mean?

Dave: yeah

NP: is it reassuring to have that there?

Dave: yes but I said all along that I would do everything in my power not to let it happen

NP: what is your understanding now of, we have sort of spoken quite a lot about this symptom, what is your understanding now of the symptom, how would you explain it, why is it there?

Dave: it is just um I don't know, how could I explain it, um I didn't read it much, I have just started to read it and think no this isn't doing anything for me, so I lose it that way and then there is a sudden oh, oh never mind

NP: have you noticed being uncertain, or unsure or doubting things now that you were previously sure of?

Dave: I am just pretty sure that if I do the right thing I know that I have to do my best to believe what I have been told, what I see, that is what I believe but I am so afraid that I am not going to be good enough, strong enough to stand up to them

NP: could you, um to stand up to what?

Dave: it

NP: the dementia, the memory loss?

Dave: mmm

NP: do you think that is what it all means, these symptoms, is that what

Dave: well what else can you do, what else can you think, you either believe what you are seeing or what you are being told and put it against you and what you think you believe and what you are being told. Sometimes the things you are being told you don't understand anyway, so you are in trouble immediately

NP: mmm

Dave: I really don't know, all I know is that particular part of me, I know how I am head wise is not letting the bad man win, I want to win

NP: mmm

Dave: that's what I want, I want to win. I don't care how [laughs] but I want to win

NP: what do you think about um being interviewed now and these questions?

Dave: trying, yeah I am not a fully, yeah well I am educated but not to your standards, I bet your glad on that [laughs] but all sorts of things like that have happened to people, my education when I was young was fabulous, I was always there

NP: mmm

Dave: always in the first three, always and top of the class and been there, done it all and was bound for the good stuff, but it never happened

NP: why not?

Dave: well I lost my dad um it was about then

NP: mmm
Dave: and it was all done
NP: how do you think that relates to these experiences in this interview?
Dave: [sighs] I missed out in a lot, in a lot of things I wanted, but then if you are one of eight and you do have a good knowledge and you try and you watch the teacher and you don't do anything silly. That is what I was like and that is why I was quite, I was up there with the others, you know. I was 10 years of age and I had my what's its name coming up um but it never came, but I did still, I went to the best school in Govan [laughs] I did, I mean I went to St Gerard's and it was a real good school at the time and it was on its way to be up somewhere else, but I think that was me and possibly not had a great showing on my life, but too late to do anything about it now [laughs]
NP: why did my asking about your interview, make you talk about schooling and education, what was the link?
Dave: I don't know, I thought I was going to be great, I really did, I loved it
NP: and does this interview, make you feel that that's not happened?
Dave: no it hasn't happened, you know, but that is not the point, I didn't ask for anything like that to happen I didn't ask my dad to die when I was 10½, I don't know, maybe I am just one of those guys, you know it's not for you but you get on and do your very best in the world and get on from there
NP: have you found any of the questions I have asked helpful, or distressing or upsetting?
Dave: mmm anything that brings a lump to your throat, that's, you know that's distressing
NP: mmm and did some of the questions do that?
Dave: yes but they would be sort of private things, things that you don't need, um things that you don't want to linger on, like your wife running off and taking your kids
NP: mmm
Dave: things like that and then you come back and try and get things going again but if it wasn't for
Jane: you've turned everything around darling; you have got your daughters back, you've got grandchildren now
Dave: I did yes, I guess I did yes, I must say I did
Jane: that is a huge, huge thing in your life
NP: mmm
Dave: yes
Jane: I think somewhere in your life you thought you were supposed to be an astronaut or something
Dave: [laughs] no
Jane: or did somebody when you were young tell you that you would never amount to anything?
Dave: no, course not when I was at school, no
Jane: not even growing up?
Dave: no
Jane: I think that you have done an amazing job for what you have been through
Dave: yes but that doesn't count, it can't cover everything
Jane: well I wouldn't just pick anyone to marry, trust me it does count
NP: well listen, we are actually just up to 59 minutes now so with your permission, we will just stop the tape, um that is all the
[End of Recording 1]

H. JANE'S TRANSCRIBED INTERVIEW

NP: So can I ask you why is your husband, in your own words, why is your husband being seen at the hospital?

Jane for vascular dementia with Alzheimer's with newly bodies, is that what it is called?

NP: Lewy bodies

Jane yes, Lewy bodies

NP: OK, so he is being seen at the hospital for dementia. More recently you have been seen again by Professor Kopelman, why was that?

Jane we came to see Professor Kopelman two years ago, wasn't it Dave, things had started to happen with your memory, but we kept putting off mentioning it to the doctor, but it got to a stage where we had to mention it to the doctor and we were referred to Professor Kopelman and they done a series of tests and you had a series of cognitive behaviour therapy, is that what it is called?

NP: mmm huh

Jane but you were top 5 in the class weren't you out of everybody he has done the test on, he said that he was in the top 5

NP: mmm huh yeah

Jane and then things gradually, they were still happening weren't they and then it gradually just got majorly worse so we asked to be referred back, we had one appointment which was I think it was last year, which you didn't want to come to, so I had to cancel it

NP: mmm

Jane but things were getting really, really bad

NP: and last week you saw Professor Kopelman I think because of some?

Jane yes we did

NP: what were those things that were?

Jane that was in April and we had had a few conversations about… I knew we were due back to Professor Kopelman, we were waiting for a brain scan, we were waiting for the appointment to happen and Professor Kopelman was saying, "if you don't get round to having the scan before you are due to come to me, we are going to have to put my appointment back until you have the scan"

NP: right

Jane but Dave's behaviour, one particular week was absolutely astronomically off the wall, and his brother was in hospital here and we were coming here to see him, and I said "would you please come to A&E with me"

NP: mmm huh

Jane because I have to get to the bottom of this

NP: what… what was the behaviour, can you tell me what you mean by the

Jane I wasn't Jane

NP: mmm huh

Jane he wanted me out of the house, hiding my keys and my phone and talking total gibberish

NP: mmm huh

Jane saying there was people in the house, there was nobody in the house and saying I was a liar, why was I saying that? and I didn't know whether maybe he could have had a urine infection or something. I had always had it in my mind, somehow when you start reading up on little things I am thinking "that ticks every box"

NP: mmm

Jane so I thought if we can get to A&E and then let's see what happens then. So we came to A&E didn't we and they done urine samples and that and he was quite confused in A&E and I said he has been like this for nearly five days. So the doctor asked him, he said "I would like to keep you in tonight for observations" but you weren't really happy were you? But I said, "please for me can you please just stay in tonight and let's see what is happening." So they took you off for, I don't know if you had a scan, he had something anyway and then they said he was really totally confused that night and they put you up on a ward, I think that was, you came in on a Saturday, they kept you in on a Saturday and I think it was on Monday night, I had only left the hospital at 9 o'clock, I was with him all day and he was quite confused and talking a load of old twaddle

NP: mmm

Jane and I thought they will get to the bottom of it and they told me they will do a brain scan, so I thought at least we can catch up on what is going on

NP: mmm

Jane and he arrived, there was a big knock on the door and he arrived at 10 o'clock at night, in the bottom of his pyjamas with no shoes or nothing, drip in his arm, he had run out of the hospital. So I said "what happened?" and he said "they were trying to get me into bed…"

NP: mmm

Jane "doing things to me" and all this I said "I have to ring them and tell them where you are"

NP: mmm

Jane so when I rang, the male nurse said "no, no, no he is in bed" and I said "I can assure you that he is not in bed" and he said "you need to get him back" and I said "I am quite happy to go in a taxi with him" and he said "no, it has to be an ambulance." So to cut a long story short and we waited up half a night and the ambulance rang, fair play, to say that they are absolutely so busy

NP: mmm

Jane and I said OK and rang the hospital back and they said obviously if anything happened to him on the way to hospital I would be responsible and I said "well fine, you know, nothing happened to him running the streets in his pyjamas"

NP: mmm huh

Jane so we got back to the hospital about half four in the morning didn't we? And he was calm and that

NP: mmm

Jane got him back into bed and I said "right, I will be back up tomorrow, 2 o'clock" or whatever and young Sarah came up, your daughter, didn't she? So when Sarah came night at 7 I said "well I am going to go now" and he was still talking a load of old, you know, about people were watching him and don't look over there and all this, so I left him with his daughter and said if there is a problem just ring me and I only got half way up the road when she phoned and said "you have to come back, dad has gone a…" whatever

NP: mmm

Jane and when I came back you were in quite a state weren't you? She had gone to get a coffee, no she had gone to the loo and when she came out of the loo there was three guys standing there with coffee or whatever and Dave's assumption of what was happening was they tried to get her into a room to rape her

NP: mmm

Jane but they were actually just getting out of the way to let her pass

NP: mmm

Jane but that is not what he saw happen, so he went ballistic anyway and she was really upset, so anyway to cut a long story short I came back, so I stayed that night with you in the hospital, if you remember, that was the first night I stayed and it was all about people trying to do stuff to him and they had done stuff to the man over there and he was next and you don't know what they do at night and all that, anyway

NP: and when, after things sort of settled down because my understanding is that um Dave was um continued to be concerned that there were other people that all looked like you

Jane yes that is where it all really kicked off

NP: yes, so when did that start?

Jane that really, when your Johnny died last year you used to talk to me sitting on the sofa sometimes thinking you were talking to Johnny and I would say "I'm not Johnny, Dave" and you would say "ahhh" and you know, do you remember in the beginning I was afraid to say to you that Johnny was dead in case it upset you, but then I thought after a couple of months I thought, "I need to try and stop this"

NP: mmm

Jane I'm not Johnny or you would say to me something about, we would be watching TV and you would say "do you remember when we went to school" and I would say "well I am not from Glasgow so I wouldn't know." So gradually, you know, you would say to me "God you're not Johnny, that's right Johnny's dead, yeah Johnny's dead." Then we would go back and you would talk to me like I was your sister and we would go back through that bit and say "Helen's dead," do you remember? And I wondered if it was that, you know, his family kind of seemed to be dwindling away

NP: mmm

Jane and this is why he sees all these people in the room because he feels safer with them, but I think it was really just, I wasn't sure I started to think "have you had a bleed, a bleed on the brain or something?"

NP: mmm

Jane or has something happened?

NP: what is your understanding of why he has been saying these funny things, it's the funny things I guess that I am more interested in

Jane I, I, I am assuming that… I don't know whether they feel this is the beginning of this, cos I think that we are further on from the beginning

NP: mmm

Jane I mean, I know we don't know where the end is, but I think it has a taken a bit of a hold on him

NP: what do you mean by that?

Jane obviously things are progressing

NP: so you mean the disease is progressing?

Jane yes and this is where all these, I think this is to me when you say about the 5 or 6 Janes, I don't know if that is you subconsciously thinking "well, OK if Jane does leave I have 5 more Janes" or whatever.

Dave: [laughs]

Jane no, it is subconsciously in your head that it is some kind of a security net for you

NP: mmm

Jane I don't know, I really don't know

NP: so that is one sort of possible explanation, so why else do you think it might be happening, that Dave is saying these things, particularly about you

Jane like I said, Dave has always been a really insecure person

NP: mmm

Jane and I think from speaking to you about your childhood, I think you were, you have always felt that you never achieved what you should have achieved and I know you felt like that, um Sally kind of made you feel like that too because she wanted you to have your own business and all that. Dave was the type, when he painted and decorated for you he would give you a price to paint your room, but Dave would hoover your carpets, clean your windows and everything, so you paid him for a week but he had done two weeks work

NP: mmm

Jane and this is where Sally kind of, his ex-wife, used to argue the tots with you, but that was the way he does the job

NP: what is the doctor's understanding of the problems do you think?

Jane I don't know, we have never, um, I mean I have been at all your meetings with Professor Kopelman, we haven't, um because there have been so many medical people in the room, and it is normally Dr Hassan who leads the questions that we are having at the moment

NP: mmm

Jane I mean my mum had Alzheimer's and she used to say daft stuff as well, like there is hedgehog under the couch or whatever, and I think it goes on with you because when he says "so where's my Jane" and I say "I'm your Jane" and he says "no you are not my Jane" and he says "don't start being stupid with me" and it gets to a level where he gets really angry and I think I am going to have to step out into the back garden or something to see if we can just diffuse the situation and I explained to him when he is back, as I call it, the next day in his mind and that, and I say I can't answer that for you I can only tell you I am here

NP: and why do you think he is saying those things?

Jane I don't know if you think because you are ill or because "she will be gone she isn't gonna stick around for this." I mean you did say to me the other day "why don't you just go and have a life" and I explained to you that you are my life and I would expect you to do the same for me. There is absolutely no question of going "ahhhhh phew, I am not sticking around for this" and I am not absolutely aware that you know exactly how much I do love you

Dave: I hope so

Jane well I always tell you and…

NP: do, do you think that is possibly why he says these things?

Jane it is the only thing I can think of, because when he says to you "oh Jane would be gone out, maybe gone to a club" or whatever and I have never gone to a club and as I says to him it really frustrates me cos I am with him 24 hours of every day and I say to him "I don't know where you are getting this from" because sometimes when I go in the morning to get the paper, the shop is there

NP: mmm

Wife I am gone 2 minutes and when I come back he says "are you just coming in now?" and I go "no, I have just got up now and I have given you your orange juice and your actimel and I went and got the paper" and he goes "no, you have just come in." I haven't actually, but I never know why you would think I have been anywhere when I never, ever have been. But this to me is what plays on his mind

NP: what do you think Dave means by saying these things, what do you think it is?

Jane I don't know. I think everything is up there; it is just getting a little bit mixed up. I don't really know, you can read anything you like about the disease, but I dare say it affects everybody quite differently depending on what is going on in your head anyway

NP: mmm, do you always know what it is he means?

Jane well he is always looking for me

NP: mmm

Jane or he will say to me, “so Jimmy has gone?” and I will say “no, it was only you and I here” and he will say “no, no, no. I have been doing the garden all day with you and your man” and I will say “no that wasn’t him, it was me”

NP: mmm

Jane because there is no him, this is another boy who doesn’t exist

NP: mmm

Jane and then we got to stage of thinking is it easier to say that he has gone, he has just left or whatever

NP: mmm

Jane but I have always promised him that I won’t lie to him

NP: mmm

Jane but if it gets him so worked up but we have thought that since they upped your medication last Wednesday, the last 2 days you have been pretty good, he will still say to me “where has everybody gone?” and I will say to him “Dave, there is nobody here, only you and me love,” and the last 2 days you have really been trying hard he says he is still thinking it but he is not saying it to me, he used to just follow me around saying “where have they gone?”

NP: mmm

Jane “why don’t you tell me?” He doesn’t, the last 2 days I am sure you haven’t, he said “I have been thinking about it but I just haven’t said it.” I’ve been going, “they must have left” but I just won’t ask and I just say that is great

NP: when he says these things does he ever explain what he means afterwards, does he ever explain why he has been asking these things

Jane no, he just gets annoyed

NP: mmm

Jane because he says “I don’t understand how you couldn’t have seen them”

NP: mmm

Jane and he says “I am distressed now, and you are a member of my family and I am asking you and you won’t answer the question”

NP: mmm

Jane and that I think upsets you more, doesn’t it?

Dave: mmm

Jane cos he is saying “why won’t you tell me cos you must have seen them?” I mean we have had it where he has said “look at the girl, the woman with the white skirt and the red cardigan” and I will say to him “come out to the garden with me” and you say there is nobody on the seat, that is because she has just got up and gone, and I think it is hard to really know what to do but you have said “look out there, it’s you know, it’s like a giraffe or something” and I will say “yes but it is actually just a plant the way it is hanging over the wall” or whatever and whether that suffices to you as an explanation or whatever but you have been not being verbally repeating it over and over again, but you have consciously made a decision to try and not do that, haven’t you?

Dave: mmm

NP: why do you think Dave keeps repeating it again and again?

Jane probably because he is not getting the answer that he actually wants to hear

NP: mmm um is it ever hard to understand what he is actually saying, not why he is saying it but?

Jane no I can always understand what he is saying, I mean it could be gobbledegook but

NP: what do you mean by that?

Jane he could be saying look at the woman standing on the wall with the giraffe under her arm and I would say to him "well number one, where would she get a giraffe?"

NP: mmm

Jane and "she wouldn't be able to get a giraffe on the wall because of the railings"

NP: mmm

Jane hoping that he will just go off onto something else

NP: what is it about it that makes it gobbledegook?

Jane well we are not talking about, well we haven't watched something on the TV where there was a woman in it and there was a giraffe in it, you know, you look out whether it is the plants or something he seems to see

NP: so it is gobbledegook because he is describing something that you don't agree with?

Jane um well it could be, we have had dafter things haven't we?

Dave: mmm

Jane or sometimes I say to him when we would be going to bed, he would be talking to me and I could be his sister, his brother or this Jimmy bloke or whatever so I think I better just turn over and go to sleep

NP: mmm

Jane because I would say to him "I am afraid to put me arms around you" because you would think, "well, who is this?" Because this has happened before and I have to wait and see how he is, going to bed

NP: mmm

Jane as to why I am going to be on any particular night, but the last, as we said, the last couple of nights you have been absolutely fine, now whether that is because they have only just doubled his medication

NP: so I am interested in how you come to the conclusion that something is gobbledegook, if you see what I mean

Jane um he would go looking; he will wander around the house looking for people. So he will go into the bathroom he will go into um and I will say to him "who, what are you looking for darling?" and he'll say nothing and then he will say um "where have they gone?" or whatever, and he'll like open the hot press and I would say, "they wouldn't be in the hot press, would they really?"

Dave: [laughs]

Jane I mean it is only that size [demonstrates size then laughs]

NP: mmm

Jane and he will go blah, blah, blah or whatever or whether he is talking to himself or he is kind of talking to me or not to me, going "I will look myself" or whatever

NP: mmm

Jane some of the things, it is like he is saying an odd sentence sort of backwards and I would say "what?"

NP: so you mean some of the sentences don't, if you like, make grammatical sense?

Jane yeah, only on an odd occasion

NP: mmm and when as you were saying talking gobbledegook it is because um I don't know I suppose I want to know um?

Jane I think that he is kind of talking to himself but saying out loud if you know what I mean?

NP: mmm

Jane I think he is saying "I don't believe these people, they couldn't have got out of the front because I have been standing in the hall" sort of thing

NP: mmm

Jane but he is saying it out loud

NP: mmm, is it easy for you tell the difference between gobbledegook and other things that he says?

Jane Dave has a look, as I call it when he is going on one, Dave has a look

NP: mmm

Jane and as soon as I see the look I think right we are going to be off now in a few minutes

NP: right

Jane and he will go into one whatever it is, like where is so and so gone and why didn't I give them some dinner

NP: mmm

Jane and why am I not speaking to them, ignoring them and have they upset me

NP: and what is the look?

Jane um I don't know how you would describe the look, it is kind of um when you used to drink, when you would be drunk, um it is kind of like um, how would I describe it, you see for me I know what the look is, if you know what I mean?

NP: yes

Jane I would just look at him and think "right, it is about to kick off now" whatever it is going to be

NP: so you can recognise it

Jane yeah it's not a vacant look it is in between a vacant look and just not happy sort of thing

NP: right

Jane for a want of a better way for trying to explain it

NP: when he says things that are hard for you to understand, what about it is difficult to understand, why is it difficult to understand?

Jane when I say some of it is hard to understand it is more about where he would get the logic of thinking what he is saying

NP: mmm

Jane and I um he would say um "I haven't seen my wife in 3 days" and I will say "Dave, I have been here" and I would go back over and say "on Monday we went to do-do-do-do and we had a coffee with um so and so" and whatever and I would say "if I wasn't here how would I know all this?" and he would say "you are a witch, yous are all witches and that is how you tell each other and you're going to tell her now and when she comes tomorrow she will tell me everything that happened because she will say that she's been there, but she wasn't there"

NP: mmm

Jane I try to think and say "ask me something nobody will know but me"

NP: mmm

Jane anything, you know, I would say to him "look at my tattoo" and he will say "you all have it"

NP: mmm

Jane the scar on my back? He'll say "you all have it" and I would say "don't you think that it is strange that we all have the same name, the same scar, the same tattoo all in the same place?" [he'll say] "not really." And trying to make logic of what the conversation is and you actually just get so exhausted and think "ahhhhhh, it will stop in a few minutes"

NP: so it is just following the track of the thought

Jane yeah

NP: the train of the thought

Jane yeah and hoping, I am hoping to bring him back to something that he will think, stupidly me thinking something will twig and he will go, yeah she is right, you know this is a load of crap

NP: mmm

Jane but it usually doesn't and we will go on for hours and I just think, you know what, I am absolutely whacked and eventually we will have a cup

of tea or something and you might fall asleep and I will think "OK I will be whoever you want me to be what the hell"

NP: what is it like having a conversation about these things?

Jane when we talk about it afterwards when he is back, as I call it, and he will say "ahhhh but that is so stupid" and I will go "yeah I know" and sometimes he will go "no, I don't believe that why would I say something like that," I don't know. In the beginning I had started to record some of the conversations on the phone, but then he would say "that is not me" and I would say "it is you Dave, if you listen to the conversation." That is when you started to believe me that there was something wrong. Although I am sure I don't even know if you are still in a bit of denial, it is a lot to accept isn't it?

NP: and when Dave is in the middle of one of these things, what is it like having a conversation with him?

Jane well most of the time I will do my best to um listen and on the odd occasion I will say to him "but that is not what happened or..."

NP: mmm

Jane we have tried all the, they say um go with the flow and if that is what he says just go with that. I have tried that, but if I say to him "Jane has just gone out to the shop she will be back in a minute" he will go "well I am going out to get her," so I am thinking "oh God, now he is going to go out on his own looking for me and I am here," so we have tried the kind of "I don't know where she is" and I go off into another room to do something and hope that the conversation changes but Dave is like a dog with a bone, when he asks you a question he won't stop

NP: right do you do anything to try and understand what he is talking about and why he is saying these things?

Jane I have sat down haven't I with you and say look how ridiculous this is, just listen to whatever I am going to say to you for a minute. We watched Countdown we had a cup of tea, you and I and you sat there and I sat here and we go through everything, but it, I am silly to myself in the sense I am thinking it will all come back to him now and he will go "she is right"

NP: mmm

Jane but it doesn't, it is, when you say what is it like to have a conversation, it is very hard to watch him so distressed and there is nothing you can do to stop it

NP: mmm

Jane nothing I can say, even if I say right Jane is next door I will go in and get her, I can't do that because when I come back in I am still going to be another Jane

NP: mmm

Jane we have to get to the stage where it is passed all that and he is starting to calm down

NP: mmm

Jane or then he suddenly, or it could be the next day or something, and he will go "thank God you are here because I don't know what happened." It is distressing for you isn't it and me to watch you

NP: what is your way of sort of understanding what Dave is saying, why he is saying it?

Jane I don't understand why he is saying it

NP: right

Jane my understanding is it is just what is going on in his head

NP: mmm

Jane I know some people go really quiet and sit down and don't say anything, but I think that it is maybe Dave's way of dealing with it that whatever is coming he is going to let it out whatever it is

NP: mmm

Jane to see if…

NP: do you think that it is relevant to anything that has happened to him in the past?

Jane only the bit about you know him thinking that I have gone out, or that I am going to leave him because of obviously the way you were after Sally left you

NP: mmm

Jane that bit I can quite understand, because even before you had all of this whenever we had any type of a barney, you would say "ahhh, you'll be going back to Ireland now, I knew you were going," and I would be thinking "I am not going anywhere actually"

NP: but there are other bits that you don't understand?

Jane oh yes

NP: do you think that he is using words in a different way to how he did before?

Jane no, no because he always had um, he has always been good with words

NP: mmm huh, so it is not like he is using words differently like sort of you know, Jane means something else now, no?

Jane no

NP: is he using words differently from other people, how other people use words?

Jane no, because we don't see that many people now really do we? Obviously we are not out, we are not big on socialising, in the last 2 years anyway, but we don't, we um see Dave's two daughters a bit and one of our friends calls round about twice a week, but it is normally me and him most of the time

NP: so it is not like he has his own way of using words that is a bit different, that is a bit changed, no?

Jane no

NP: does he say anything that sort of confuses or surprises you?

Jane no, sometimes he does this sort of giddy thing, again he used to do it when you would be drunk, it is like um, a mad laugh, like "ha, ha, ha, ha we are going into the garden today ha, ha, ha, ha" and I would think "oh God." It was just like that when you were drunk. Honestly there is very little difference of your facial and the way you do it

NP: mmm does he ever seem uncertain or questioning of things that he wouldn't have before?

Jane quite a lot of the time, I feel that, um if we are watching things on TV and that, you can't concentrate can you? Or we put a movie on and that, I am thinking after about 10 minutes, "I'll think I'll just change it" because I know that he is just not getting it, and I find that with lots of movies now. I am thinking there is not really much point in watching them. I mean some can be really tricky to follow but…

NP: I guess I mean the sort of things before he would have been certain about you know, does he?

Jane he has come quite suspicious about things

NP: uhuh, about what things?

Jane I mean you started these things with these Janes, about - you know we moved, we used to live on the fourth floor and we moved down and we now have a garden on the ground floor - about how many people have keys

NP: mmm

Jane and he was saying "I don't think we are going to get it because of Jimmy and the other Jane are going to get that flat A"

NP: mmm

Jane and I would say "but they won't because there is only you and me"

NP: mmm

Jane and he would say “but they all have keys, they must have keys that is how they get in” and I would say “that they weren’t here, because they don’t exist”

NP: mmm

Jane so they haven’t got keys, so we went through this period but you haven’t been too bad about that have you lately?

Dave: no

Jane thinking that lots of people had keys

NP: mmm

Jane but [yawns] that was the only thing really

NP: do you think that when Dave is saying these things he is really talking about something else?

Jane no, I think that he honestly thinks that other people have, he knows that our friend Liz in case we lock ourselves out has a set, but he thinks that the way these other Janes have come about, and even though I have done my best to convince him that they don’t actually exist

NP: mmm

Jane to him they do, but that is fair enough, though therefore, as he says, if they are in the house they must have keys

NP: and is there anyone that you know from Dave’s past um that might be able to sort of understand these things, um unravel sort of what it is all about

Jane no I don’t think so

NP: do you ever talk to other people that have sort of known him to try and work out is there, is there something going on there

Jane no I don’t think um I speak to your sister in law all the time, I don’t um you had um 10 sessions with Dr Joe and you said that you talked about stuff and he went over stuff with you, but obviously that was between you and him and that was fine, but not as far as I know, there is anything

NP: do you think that Dave must always be meaning something by what he is saying?

Jane well I have never sort of thought about um Dave actually just saying something for the sake of saying it if you know what I mean

NP: I suppose you know when you said gobbledegook, it sort of sounds like that’s…

Jane that’s kind of like as I said when he kind of looks in the cupboard going well they must be in here somewhere because they didn’t get out of the door, but I think that he is just sort of talking out loud, so he is not actually…

NP: mmm do you always do your very best to understand what it is he is trying to say?

Jane and then I dread it because after there will be a question, and then I have to try and decide how I am going to answer this question

NP: mmm

Jane do I say yes they have just gone out, no they weren’t here at all, they don’t exist?

NP: mmm

Jane its…

NP: and how do you sort of go about trying to understand it?

Jane I am at the stage where now I sort of try to distract you, don’t I, into talking about something else or whatever? Or sometimes because he has been, you have been so good in the last couple of days since they have doubled your medication, if he says I am going to tell Jane blah, blah, blah and I go to him “yoo-hoo it is me,” and he goes “OK,” and I am thinking half the time you probably don’t believe me but if you are satisfied with that answer, that is great

NP: mmm

Jane but you really have been working hard on it haven't you? Even though he may be saying to himself "no, it isn't her," but I will let it go, and I think that is fine as long as we don't have a drama about it

NP: have you ever given up trying to understand what he is saying, what he means?

Jane no, I mean I do always listen even though he doesn't think that I do listen, obviously, because I am not there according to him sometimes

NP: mmm

Jane I do listen. It is always really about where these people have been, where they have gone? are they coming back? why they are not having dinner? and why I am not speaking to them? that is the only thing we go on about

NP: do you ever get to the point where you just go, I don't understand why he is saying this, what does it all mean?

Jane well it is only and Dave in the house so sometimes I, I did say to you one day it went on for so long, I said "look, can you do me a favour, could you just stop talking for 10 minutes"

NP: mmm

Jane "and let me have 10 minutes and then you can ask me anything you want"

NP: mmm

Jane because it was getting, we do have days when I think "aghh," because he does follow you all around the house and I think "aghh, for God's sake just give me 2 minutes." It can be really, really difficult and it is difficult because of not knowing how to answer his questions

NP: mmm

Jane because sometimes you feel like saying "hello, there's nobody here" but

NP: but it sounds like you always do your level best to give him an answer

Jane well as far as I am concerned I do, some sort of an answer

NP: mmm

Jane and then I say when he starts talking normally about what is on TV or whatever

NP: mmm

Jane "the reason why I can't give you that answer is because there was nobody here"

NP: right, right

Jane and then I will say to him "when you read that thing about, you'll perceive something else but it will be true to what you think has happened which is fair enough, but it is not actually what I have seen"

NP: mmm

Jane because sometimes then he will say "I think that you have a problem with you memory" then [laughs] yeah OK maybe [laughs]

NP: mmm so you have never sot of really come to the conclusion that "I just cannot understand what you are talking about"

Jane no he always makes himself…

NP: clear

Jane yeah clear, what it is, who he is looking for or…

NP: has Dave saying some of these odd things, has that changed the way you think about other things that he says?

Jane no, but it makes me think that this started a lot longer than we thought it did because it would um explain some of his behaviour when he used to drink

NP: right

Jane so I am thinking it probably was, things were starting back then

NP: yeah, when was that?

Jane um I think you haven't really drunk more for 2 years now, have you?

Dave: more than that

NP: what does it explain?

Jane well we would be sitting in the pub having a conversation or whatever and all of a sudden when we get home he will say "I was totally ignored, I may as well not have been there" and I used to think "you need to get hearing aids, if that is what happening and you can't hear the conversation"

NP mmm

Jane "maybe that is why you are getting annoyed?" He always used to say "I felt totally left out and there wasn't much point in me being there as yous were all…" and I used to say when we all get together for a drink and we are talking across the table and that

NP: mmm

Jane he used to hate it, didn't you?

Dave: [sighs] sometimes

Jane and he used to get quite mad and annoyed and I really thought it was his hearing

NP: mmm

Jane but then when this all came about I thought "I wonder if it was because?" especially if, we are Irish people and we talk quite quickly

NP: mmm

Jane was it that he was thinking "whoa God this is going way too quick for me" and not being able to um if we are asking each other questions and talking about something, he is thinking "God I can't in on this because I didn't even get half the question." But I think it might maybe explain some of it and then if we had a big row over the drink he would say "I don't remember, I don't remember that at all, I don't have no recollection of that at all" and I would think "you are lucky you don't remember it" but hey you know maybe he actually didn't

NP: is it easy for you to tell the difference between the things that is sort of easy to understand and these sort of more difficult things?

Jane um I understand everything that he is saying

NP: mmm

Jane it can be difficult to go through some of the things, you know they [professionals] say um sit down and work out a plan and you know talk about things for the future and that, but sometimes we hit on it and then you go "this is going to get so upsetting and do we really need to do this today, are we going to start off on a bad day?" so I kind of, its um, I don't know um how would I describe it um, it would be lovely to say "OK let's be logical about this, sit down now and work everything out while you are reasonably OK"

NP: mmm

Jane so whatever it is you want, if something happens to you we have it all written down so your daughters know, I know so there is, um so nobody can make a mistake about that, and he will say "don't be so silly what are you talking about I'm fine"

NP: mmm

Jane and then I go "OK" but I think that is something that we both need to do one day

Dave: yeah

Jane even me, you know because everyone always goes "so and so will know what to do," but that is not the point because you can just leave it um, I would like to be cremated, OK fine there is a start

NP: mmm

Jane everyone goes "I don't want to talk about it" but I really do think that everybody should do it

NP: do you think that this is related to some of the things that Dave is saying?

Jane I don't know, I really don't know if this is a stage that you go through with this dementia

NP: you mentioned denial, do you think that?

Jane I think a lot of the time Dave thinks "they got it wrong you know, they are looking at somebody else's results because they are not mine"

NP: mmm

Jane I do think that because when, sometimes when you are having a good day you know and before, I wouldn't, I would say to you know when he gets all confused about stuff, I would say "this is what your illness does to you" and he would go "what fucking illness?" and then I would say, I didn't want to say the d word, I would say "your vascular problem with the blood flow to your brain." "Oh for fucks sake, I don't know what you're saying." [talking form his perspective] So you're swearing, that is what I say and I am not

NP: mmm

Jane I don't know, I think sometimes you think that in 6 or 12 months' time you're going to beat this thing and go "hey, I told you," which is fine, if that is what, you know, if that is what works for you

NP: do you think that that explains some of the things that Dave is saying?

Jane I don't know, you haven't said anything overly whacky in a sense

Dave: I thought that I gave quite a half decent account of myself

NP: yeah you did

Jane no I don't mean here, I mean at home, when we are at home just doing our daily this that and the other, but then the last time Alexis was with us you asked me to leave because, obviously, I wasn't Jane your wife. Do you remember I went out in the garden so you would speak?

Dave: yes

Jane so you could speak to her on your own or whatever, I don't know he hasn't said anything that, is sort of, think "my God what is he talking about,?" do you know what I mean? Whatever it is, he obviously knows what he means himself

NP: mmm

Jane well you know I keep, we have started to do this jigsaw and I keep calling it a crossword, and all the time I keep saying to him "shall we have a go at the crossword" and he goes "it's a jigsaw" [laughs] and I just keep doing it

NP: mmm what do you understand of the Misidentification Syndrome?

Jane I have never um it really bugged me in the beginning, as I said to him when he would come back as I would call it, "I don't understand if because you know who everybody is, every neighbour in this block you go hello John, hello Charlie or whatever, what is it with me?"

NP: mmm

Jane why are there 7 Janes or 5 Janes or you think I am this Jimmy guy or whoever?

NP: mmm

Jane but it really didn't, and I don't understand it, and in the beginning when his daughters would come, he would think is she making this up that she does this and I used to say to him "oh, that's it. Keep off of me" and I used to say "it is like you are putting it on," but I think that was you trying your best to not to say anything that might alert them to, I think you were trying extra hard, I mean the first time after you had been diagnosed, after when we went down to Clare's, you were fairly quiet and to me you were being quiet rather than say something that they will go…. You know what I mean?

Dave: I will tell the girls

Jane I mean they know, but I am just saying that the first time you seemed to me if I don't say anything, I can't put my foot in it sort of thing

NP: why do you think that it is you that he has this misidentification thing for?

Jane probably because I am with him 24 hours a day, that is the only thing that I can think of

NP: but why, could you elaborate on that, why do you think that would explain that you are, sort of, the person that ?

Jane well I don't know, he may think that I say to him "no Dave, it is me I am with you 24 hours every day, I am always with you even at night" and I am sure I don't know if he is thinking it is impossible for anyone to be with someone 24 hours a day. I don't know as I said, are these extra Janes a little net for Dave? So he goes "well if you decide to say 'OK I have had enough, I can't do this I'm going'"

NP: mmm

Jane well he goes "OK, well I have got the other Janes it won't be a problem I can do this"

NP: do you think that the dementia is involved in these symptoms, this symptom, the misidentification symptom?

Jane I would have thought so

NP: yeah

Jane I would have thought so. Well I don't really know exactly what it is, obviously parts of your brain dies gradually and information kind of gets muddled up. I don't, I don't really know

NP: so would you go more for a muddled up rather than it is to do with some sort of life experience?

Jane it could well be to do with some sort of life experience

NP: mmm

Jane but I don't know whether you have had one of those sort of life experiences where you think… God I hope you never find it [laughs], if you know what I mean. I don't, I don't really know

NP: mmm

Jane I mean, I know when you were younger and you had a drink or that with the boys, that you were always quite explosive if anything kicked off

Dave: when I was the age for drinking, I was 16 I think

Jane you had that twitch thing when you were young

Dave: I had loads and loads of them

Jane for years you used to do this [demonstrates tic]

Dave: it was a nervous thing, but all that, you know drinking and thing, drinking with all the..

Jane the boys

Dave: all the hard cases from Dublin and all that, I never ever got involved

NP: mmm

Jane no, I am not trying to um paint a picture of you being an alcoholic or something I am just saying you were always, how would I say it, you were always, when you were out with the lads and out drinking, you were always one of the lads

NP: mmm

Dave: oh yes that must have been when I was older, because I couldn't drink, I could not get into the pubs here and I was 21 and they would not serve me

Jane because you looked so young didn't you?

Dave: yes, I did it was not my fault, I hated it… hated it

Jane you don't hate it now do you?

Dave: no, it is a bit different [laughs]

Jane [laughs]

NP: of course [laughs] have these things that Dave has been saying sort of changed the way that you react to Dave or respond?

Jane no not really, I know when Dave gets to a point when he gets really, really annoyed when I need to just step outside now because we just need to try and let things calm down or whatever

NP: but in the main it hasn't sort of changed the way you react or the way you feel?

Jane no, not really. In the beginning I would have repeatedly thought, "surely we can hold this thing back" and I would say to him "I am going to tell you the truth no matter what happens and say I am Jane your wife, we were married" blah, blah, blah, blah, and I go through everything over and over again but obviously it doesn't work and then I thought "you know what? As long as he," I said to him "as long as you are happy being with me and you're safe and you're washed and you're looked after and whatever it doesn't really matter who you think I am," so let's go for that one

NP: mmm

Jane but then it came about, so then where is Jane?

NP: mmm

Jane but I think that I have learnt that I do everything at about 100mph and I like to be up in the morning everything done and cleaned and whatever, and I was thinking "I can do this, I can sort him out and do everything," but no I can't, and I had to come to realise that no I am not superwoman, and really I don't have to be superwoman and if the washing doesn't get done today it doesn't get done today and it is not the end of the world. So we have just, we have just kind of gently changed a few things, haven't we? We say "we will still do everything that we have always done, but we will just do it much, much slower" and if we are coming to your house for dinner and dinner is at 6 I will say "we will do our best to get there at 6 but we are not going to stress out about it"

NP: mmm have you found it, obviously dementia is a difficult diagnosis to hear, but have you found that these experiences sort of make more sense to you, having had the diagnosis?

Jane yes absolutely, it was nice for someone to actually say well you know what it is and you can thank God at last

NP: mmm

Jane but I mean when you had the second set of tests this year, as I said Dr Joe said that he could not believe the difference in the 2 years

NP: mmm

Jane he just couldn't, could he?

Dave: no

Jane and your weight, I mean your weight has just disappeared off him

NP: right

Jane isn't it?

Dave: I weigh nothing at all, because I was quite

Jane you were all there

Dave: and the shoulders were [laughs]

Jane he is putting it on me when he is asleep

NP: [laughs] what do you think about being interviewed about all of these things

Jane I don't mind, for me I find it quite helpful to actually talk to someone, because I am with Dave 24 hours a day. That is not meaning that we don't have conversations

NP: mmm yeah

Jane but it is actually, just nice to chat to somebody else, no and I think that if it can be of any help to anybody I am all for whatever you know, we can do it and help ourselves as we are doing it as well

NP: right well I think that is everything I have got to ask, certainly at the moment, maybe that I will sort of look through the tape and er

Jane mmm huh
NP: the transcripts and er come back to you if that is OK?
Jane fine
NP: it probably be a, certainly be a month away anyway
Jane no problem
NP: er so thanks very much for your time
Jane no probs
NP: do you guys have any questions for me
Jane I bet you feel like a marriage counsellor now, don't you?
NP: [laughs]
Jane [laughs] no I just hope it has been helpful for you
NP: it has certainly been helpful for me
Jane good
NP: yeah I hope that it has been helpful for you guys
Dave: thank you very, very much indeed
NP: thank you
Dave: and I hope that it has been helpful for you
NP: it certainly has
Jane yeah
NP: yes, it certainly has
Jane get on top of it and sort it out for some of these poor people on the way up. We get to keep this don't we yep?
NP: yes I would like you to keep that as well [information sheets]
Jane OK
[End of transcription]

I. LIZ'S TRANSCRIBED INTERVIEW

NP: Um so can you tell me in your own words why it is that you have been seen at the hospital, why have you been seen by Professor Kopelman?

Liz: I was being seen because I had a severe heart attack, I died and they brought me back but it has left this part of the brain no good, not working that is the cause

NP: mmm huh

Liz: and ever since then I haven't been right

NP: ok

Liz: I do things in doors which I shouldn't.

NP: ok

Liz: I put tea towels in the oven to cook instead of a roast dinner or something

NP: mmm

Liz: now I can't bend down to do anything now

NP: ok

Liz: in the cooker, because I will drop everything. And er go to bed of a night and turn everything off, well you think you have, you take your animals off the bed and dolls which I have had since I was a child, which my kids bought me and er… and I am laughing and the flowers on my window sill they dance and I think to myself what is going on and then I see people in my place on bikes, walking around. But they never talk

NP: mmm

Liz: they just laugh.

NP: right

Liz: I have never had that and it is scary

NP: yeah

Liz: it is, it is for me.

NP: yeah, that does sound scary. Um so it sounds like the problem is that you are seeing things

Liz: seeing things and hearing things.

NP: what are you hearing?

Liz: my animals, my dolls that sit on my bed. Now I have taken them off

NP: mmm huh

Liz: and put them in black bags, but you go to bed and you can still hear them

NP: what, hear what?

Liz: laughing…

NP: right

Liz: and making noises

NP: mmm

Liz: and I know, I know it can't be true, animals don't talk to you

NP: mmm

Liz: unless they are real, but mine do.

NP: so um what animals is that?

Liz: I have got a bear on my bed. I have got a rabbit on my bed, which I did do until a couple of weeks ago

NP: mmm

Liz: so I put them all in bag black.

NP: so obviously these are dolls

Liz: yeah

NP: right I see

Liz: yeah

NP: so it is the dolls that are talking to you
Liz: yeah it is scary
NP: mmm
Liz: and me flowers on my window sill they dance.
NP: what do they say to you, when you say they speak to you?
Liz: they just laugh.
NP: so it is laughing
Liz: just laughing at me. And you think to yourself why and you stand there and look at them, but they are not doing anything but it is in your mind, they are doing it to you
NP: yeah
Liz: what for? I have had four different people in my place, don't know them from Adam, sitting on the bike, you know they have got one foot on the wheel and the other foot, sort of like his toes are on the floor, and I can always remember him. He wasn't young, he was elderly, he had grey hair, white shirt with cufflinks on and these grey trousers. I can see his face who, he is I do not know
NP: what was his face like?
Liz: sorry?
NP: what did he look like?
Liz: he looked clean, he, he never had um bad skin
NP: mmm
Liz: his face was clear, and he just sat there and I said to him "what are you doing in my flat?" and he just laughed and I said to him "get out" and he went. Then I have had women in my place, and they looked so tall
NP: mmm huh
Liz: and I just think to myself, "who are you?" I don't know none of them
NP: and how tall?
Liz: I would say about 7 foot if you are lying in bed and looking up
NP: mmm
Liz: her head was nearly reaching the ceiling
NP: right
Liz: and I, I get panicky
NP: mmm
Liz: I had to get out and of course I fall
NP: yeah
Liz: cos I got very high blood pressure
NP: ok
Liz: and diabetes and I just said "what is going on?" I had my daughter staying with me for four days a couple of months ago and she said "mum are you up" "yeah I said "I'll sleep in the living room." That was fine, you can't live in the living room and sleep, because she had my bed, because it has got a machine on it
NP: right
Liz: so I can lift my head up
NP: oh right
Liz: because I can't lay flat
NP: yes
Liz: so she said "get in your own bed I will sleep out here," but I said "no, you sleep in the bed and I will sleep in the living room"
NP: and that was because you were too scared to sleep in there
Liz: yeah, yeah
NP: yeah
Liz: so I am getting there, before I go to bed I have a look to see if everything… no one is there
NP: yeah
Liz: it is a very, um I have never been like this in my life, ever
NP: so the main problems for you are hearing this laughter

Liz: yeah
NP: and seeing strange people in your house
Liz: yeah walking in and out
NP: and also seeing the flowers dance that also seems to be
Liz: yeah
NP: something that you mentioned
Liz: yeah every night, I wish, I just wish that they would leave me alone
NP: yeah
Liz: I live on my own and it is very scary… when you know that you have to watch everything in your home
NP: mmm
Liz: you know, I might actually what you say… not really scared because they are my animals I have had them so long
NP: mmm
Liz: but it is just the noise and the laughter
NP: mmm
Liz: what frighten me
NP: what do you mean you are not really scared because you have had them long, why wouldn't it be scary?
Liz: well why should it be scary, I know it is only animals
NP: mmm
Liz: on my bed. And when I take them off of a night well I put them all away now
NP: mmm
Liz: I am trying it
NP: mmm
Liz: but when I take them off of a night, it seems fine but it is when I get into bed and you are just getting comfortable
NP: mmm
Liz: to lay down and sleep, that is when It starts
NP: and when you hear the laughter?
Liz: it frightens me
NP: yeah and do you think that the dolls are laughing
Liz: yeah
NP: or is it?
Liz: no it is all in my mind, it has got to be.
NP: right, so do you think that they are laughing or not?
Liz: in some ways yes, but in other ways I say to myself no they are not laughing
NP: mmm
Liz: how can a doll laugh?
NP: mmm
Liz: it has got no battery or anything on them
NP: yeah, so that is kind of how you reason then is it?
Liz: yeah
NP: it can't be the dolls
Liz: yeah
NP: because they don't have any batteries in them
Liz: but how does the flowers dance?
NP: mmm
Liz: they are only artificial; I mean I have them in every room
NP: mmm what is your understanding of this problem, what do you think is causing this problem?
Liz: me, me. Now this part of the brain is not working
NP: mmm huh
Liz: it's me
NP: right
Liz: I imagine things, I have got to

NP: mmm
Liz: for this to happen to me, I have never been like it in my life
NP: so are you 100% sure that, that it is that part of your brain not working or
Liz: I think so
NP: right
Liz: I can't prove it but
NP: mmm
Liz: I have got to have proof done on me to see if it is
NP: right
Liz: I have lost 3 stone in weight
NP: right
Liz: cos I am frightened to do anything
NP: mmm
Liz: in case anybody is in my place
NP: mmm so it sounds like sometimes you think that it is you and
Liz: yeah
NP: sometimes you are not so sure
Liz: no, no. why does it start when I am in bed and not during the days?
NP: mmm
Liz: tell me?
NP: what do you think, why do you think that
Liz: I don't know, I have been asking myself "why?"
NP: mmm
Liz: and once you wake up you can't go back to sleep
NP: mmm
Liz: I have to get up, I can't go back to sleep
NP: mmm so what do you think is the cause of the laughter?
Liz: I don't know it is hard to think, what is the laughter, why are they laughing, I don't know. I wish someone would tell me
NP: mmm
Liz: and to see these... well to me they look like angels
NP: mmm
Liz: these very tall people
NP: mmm
Liz: I could be wrong, I don't know
NP: mmm
Liz: but they seem very tall when you are lying in bed, but they haven't got no wings
NP: mmm
Liz: they have just got old fashioned clothes on
NP: mmm old fashioned clothes
Liz: yeah old fashioned
NP: what do you mean?
Liz: what they wore in the 20's
NP: right
Liz: like the big padded shoulders
NP: right
Liz: and all this garment they wore
NP: what do you mean all this?
Liz: [laughs]
NP: describe that, because it is like [laughs]
Liz: it is like all frills what come out and they come round in a big wide square at the bottom
NP: big frilly… ball gowns
Liz: yeah, yeah, yeah
NP: that sort of thing

Liz: yeah, why I have never been to a ball place in my life
NP: mmm
Liz: I don't even go out much like I used to
NP: yeah
Liz: it has stopped me from doing a lot of things
NP: yeah and um what do you think is happening, what do you think is?
Liz: I don't know; perhaps it is time for me to go, I don't know
NP: what do you mean by that?
Liz: well, it is just a word you use isn't it. Oh well It won't be long before I am down there. You know it is just a word you use
NP: mmm huh
Liz: I say it a lot
NP: mmm huh, so do you think these women, this stuff signifies that?
Liz: yeah
NP: in what way, how does it signify that?
Liz: I don't know, I don't know, but it makes me feel ill
NP: right
Liz: of a morning
NP: mmm
Liz: when I get up
NP: you mean is it that the experiences make you feel unwell, or is it that you think I must be unwell to have these experiences? Do you see what I mean?
Liz: I, I, I don't know, if I can answer that question. Because it is so funny how they can get in and when you tell them to go, they go.
NP: mmm huh
Liz: where? Where do they go to? You don't know, I don't know
NP: so if you tell them to go they suddenly disappear
Liz: they disappear like the bloke on the bike.
NP: mmm
Liz: he had a black bike with a white bar on it.
NP: mmm
Liz: I can see it plainly.
NP: have you ever seen anything like that
Liz: no
NP: before?
Liz: never in my life
NP: right
Liz: no I was always going to bed, saying goodnight to my other half before he died, and that was it
NP: mmm
Liz: but now everything seems to be coming
NP: mmm
Liz: I don't know the people
NP: do the people signify anything to you, you know
Liz: no they just laugh, they just laugh
NP: they just laugh and, and do they
Liz: they don't shout out laughing, they just sort of smile, you know and they just look at you and go, but where do they go to?
NP: do they have funny looking faces or anything?
Liz: [laughs] well, you say that
NP: [laughs]
Liz: I cant be honest and truthful about that because every time you try to look at their faces they turn, so what are they? I don't know.
NP: what do you think they are?
Liz: ghosts? I don't know, I just don't know
NP: when did you first notice this problem?
Liz: after I got better in the hospital, when I started going home

NP: mmm
Liz: it happened about a month after, things started going funny indoors, and you think you put something down in the place and when you went to go and get it, it was gone.
NP: mmm huh
Liz: you think, I am sure I put it on there; you sure? Yeah I am definitely sure I put it on there, but it is not there
NP: mmm
Liz: then it will take about 3 or 4 weeks, then you will find it. Why? Why do things go walkies? I don't know
NP: mmm any thoughts, any suspicions about what might be happening?
Liz: no, I would like you to tell me
NP: um and how long ago was this?
Liz: 5 years ago
NP: 5 years ago
Liz: yeah when I had the brain er heart attack
NP: so this has been going on
Liz: yeah, I was going down Moss Street
NP: mmm
Liz: down Jamaica Road
NP: mmm
Liz: I was going there, and they sent me here
NP: mmm
Liz: I done about just over a year there
NP: right
Liz: with them, very nice people
NP: mmm
Liz: understanding
NP: mmm
Liz: oh yeah and then I started coming here, and I liked it here
NP: mmm
Liz: because they knew what to say to me
NP: mmm
Liz: you can't talk to a woman, what you can talk to a man
NP: mmm
Liz: in some of my things, I don't let everybody know what goes on.
NP: right
Liz: I was sort of like try and hold my head up high, you know. It is funny how things go with somebody else's brain.
NP: mmm
Liz: you know?
NP: what was er so the first thing you noticed was things going missing
Liz: yeah
NP: then what, then after that what did you begin to notice? What?
Liz: me dolls laughing
NP: mmm
Liz: that is when I, when it first started
NP: yeah
Liz: then my other half come to me, he come to me twice and er I called him a few names
NP: mmm
Liz: because he played around. I didn't know until the last minute
NP: right
Liz: and I just told him to go
NP: mmm huh
Liz: and he went, I can remember his arms just about to go around me
NP: mmm huh

Liz: and I said "get out and don't ever come back" and he has never come back. Is he doing this to me? I don't know
NP: so your husband had passed away by this point, is that right?
Liz: yeah
NP: and then you saw him
Liz: yeah
NP: and he was about to give you a hug
Liz: yeah
NP: but you were still angry with him
Liz: yeah I was still very angry with him, yeah
NP: mmm
Liz: he played around
NP: so that was one of the first things you noticed?
Liz: yeah
NP: one of the first visual things that you noticed?
Liz: yeah and then when I told him to go, this is what started happening to me with me animals
NP: mmm
Liz: and it all sort of came to a life if you like to say, and started er laughing and everything and that frightened me
NP: mmm
Liz: so now I go to bed with earplugs in and all the dolls and that I put in a black bag and tie the black bags, but I lay there and listen, I listen and I take my ear plug out and I can hear them and I put them back in again.
NP: mmm
Liz: so I can have a good night's sleep
NP: and by putting the earplug in does that stop it?
Liz: well it stops me hearing them
NP: yes
Liz: but I know that they are there
NP: mmm
Liz: I can't throw them away and I can't give them to my kids
NP: why not?
Liz: because it was my kids who bought them for me
NP: mmm huh
Liz: on holiday, me doll stands that high on the bed, I got another one that stands that high and I got a very old fashioned one, with the little purse on her, around her neck and long legs
NP: mmm
Liz: she lays on the bed
NP: mmm
Liz: but I have had to put them all in a black bag now, to stop me from hearing them
NP: right so it sounds like you think that it is more the dolls rather than the bit going wrong in the brain
Liz: mmm [affirmative]
NP: so you think that the dolls are laughing?
Liz: I think that they are
NP: and why, why would they laugh at you?
Liz: I don't know, this is what I have been trying to find out myself. Why does dolls who haven't got no press buttons on them
NP: mmm
Liz: can sit there and laugh.
NP: and you mentioned your husband, how do you think that he relates to this?
Liz: well it is very hard to say, he was a good man in his younger days but now… I shall never forgive him. I see her every day, the girl he played around with

NP: mmm
Liz: and she just stands there and looks at me
NP: mmm
Liz: I don't know
NP: and do you think that she is laughing at you or he is laughing at you?
Liz: oh she stands and stares at me
NP: mmm
Liz: and I do a very naughty thing [V-sign gesture made]
NP: [laughs]
Liz: I am being honest with you
NP: mmm
Liz: I do that every time I see her
NP: so you give her the V sign
Liz: mmm cos I mean he had everything
NP: mmm
Liz: he had everything, but to do this on me
NP: how did you find out?
Liz: she'd come and told me
NP: after he died
Liz: mmm and I gave her a smack
NP: mmm
Liz: and that is it. I just want her to keep away
NP: mmm
Liz: and he to rest in peace, that's all
NP: so do you think that all of these things are somehow related?
Liz: it could be, it could not be, I don't know
NP: so you are just not sure
Liz: I'm not sure myself
NP: what do the doctors say is the matter?
Liz: what?
NP: what do the doctors say is the matter?
Liz: matter with what?
NP: sorry, what do the doctors, er have the doctors given you any explanation as to what they think is going on?
Liz: no
NP: they have never explained
Liz: no
NP: they have never given you a
Liz: no, they have never explained anything to me
NP: no
Liz: they gave me tablets, I've got tablets coming out of my earholes, but they never explained
NP: no
Liz: they just said "your brain is dead, on the left side"
NP: right
Liz: that is all I have been told
NP: ok, so that is some sort of an explanation
Liz: yeah but it is not the full explanation
NP: mmm
Liz: they haven't said "oh, it will be alright again soon" or
NP: mmm
Liz: or "you can have treatment" or anything
NP: right
Liz: I've had scans on me head the other week in the hospital, but they don't tell you nothing
NP: yeah
Liz: what's going on up there, but I don't want to be one of these people who go mad

NP: mmm
Liz: I mean you see a lot of bad people gone mad
NP: mmm
Liz: I don't want to be like that, I want to be like I was and how I should be, now
NP: right
Liz: but I'm not
NP: um what did you think of the doctor's explanation; you know that part of the brain is dead
Liz: what did it think?... I always think why is a part of your brain dead? but you've got, you can still do things, you can still talk
NP: mmm
Liz: I mean I have known people; well Valerie had a really big heart attack
NP: mmm
Liz: and they have lost her brain a bit, but they still carry on
NP: mmm
Liz: why can't I still carry on?
NP: mmm
Liz: it doesn't make sense
NP: yeah, so do you mean um the doctor's explanation doesn't make sense?
Liz: no
NP: it doesn't make sense to you?
Liz: no
NP: so what about it, what is it that doesn't make sense? Try and sort of
Liz: well, I know that I forget a lot of things now and I have to write things on a bit of paper and stick it on me freezer
NP: mmm
Liz: and I leave around my things and I put it on me freezer, what have I got to do, what have I got to get, I mustn't forget to do this and I mustn't forget to do that, but why? I never used to have to do that, but now I am doing it
NP: mmm
Liz: like when you phoned, right I have to make sure
NP: mmm
Liz: I phone the car to pick me up, it came, you know, now what's his name, I forgot it, but you phoned me
NP: mmm
Liz: that's it
NP: mmm
Liz: that's how I am, every day, now what have I got to do today? oh I got to ring me daughter, oh I got to do this today, yeah if I don't do it, it won't get done, all stupid things
NP: mmm
Liz: and I shouldn't have to keep on doing it
NP: did you believe the doctors explanation, do you think that it was correct?
Liz: in one way cos I know how I turned round, in one way, there is something gone wrong with this, I don't know what part of the brain, but they said that it was the left side
NP: mmm
Liz: but, I have never been like this
NP: mmm
Liz: I have always been happy go lucky, go out with friends and that, now I don't want to do nothing
NP: um so do you think that the doctors, do they understand the problems, do you think that they feel that they have
Liz: I don't know, they haven't said anything to me cos all they told me is my brain has gone dead on the left side, that is all they have said

NP: that's all they've said ok
Liz: they haven't said nothing else to me
NP: mmm do you think that that could explain all of the different sort of experiences you are having?
Liz: well most probably, well I wouldn't know would I?
NP: mmm
Liz: cos I never had it before
NP: mmm
Liz: if I spoke to someone who had anything like I went through, you know perhaps I would understand more
NP: mmm
Liz: but surely it could get better
NP: so it sounds like it never really does get better
Liz: no
NP: do other people understand what you are telling them when you are telling them about these experiences?
Liz: well um me friends don't understand, they laugh at me
NP: mmm
Liz: "how can your brain be dead if you are still talking?"
NP: mmm
Liz: which is right, I say
NP: mmm
Liz: why is your brain still not working? then you think to yourself well it is only on one side what is the matter with the other side
NP: mmm
Liz: that is the way I look at it, but they laugh at me and say "don't talk stupid you haven't got a dead brain"
NP: mmm
Liz: "if you had a dead brain you wouldn't be able to do this and that"
NP: mmm
Liz: which is right
NP: yeah
Liz: it's got to be
NP: and what about the experiences that you are going through, do they understand when you explain them?
Liz: no
NP: do you tell them about them?
Liz: I have told er a couple of them
NP: mmm
Liz: but it goes through their ear and out the other end, they are not really interested
NP: mmm
Liz: when I tell them about things I have seen and what's been done and that, they say that "it is all in your head…
NP: mmm
Liz: you are imagining it all," I say I wish I was
NP: mmm
Liz: but how can you imagine people in your home when it wakes you up?
NP: mmm and do they understand what it is you are telling them, I mean do they understand what you are saying to them?
Liz: I don't know that, I don't repeat no more now
NP: right
Liz: I keep things to myself
NP: right
Liz: or I see the doctor up here or whoever
NP: why is that? Why do you keep it to yourself?
Liz: because people laugh
NP: mmm

Liz: they laugh at me and I know up here I can sit and talk to the doctor and he can talk to me
NP: mmm
Liz: and that is as far as it goes
NP: right
Liz: I don't go home and say guess what the doctors have said to me blah, blah, blah, blah, no that is not me. If the doctor has got something on his mind that he wants to tell me, let him tell me
NP: mmm
Liz: don't keep me, um hidden, I am still a human being
NP: right, do you, do other people believe you when you tell them about these experiences?
Liz: yeah, yeah a couple of me other friends do
NP: mmm
Liz: because there was a girl who lost her mother, I think she said died about 3 years ago with cancer, and her mum came to see her after she died
NP: mmm
Liz: and told her to behave herself and look after herself, see like a mother would with her child
NP: mmm
Liz: cos she had a bad illness
NP: mmm
Liz: so I said "that was nice," but she said "it wasn't my mum," so I said "who was it then?" she said "I don't know, it didn't even look like my mum." Mmm, well I thought everybody I have seen who has died who have been cremated they have been the ones I know
NP: mmm
Liz: but I've never see her mum
NP: right
Liz: but she says it wasn't her mother
NP: right
Liz: but why? You can't bury, well you can't cremate somebody who is not your mother, surely
NP: yeah
Liz: well I, I just don't know
NP: so it sounds like you are quite confused by
Liz: yeah I can't, I am really confused about everything
NP: mmm do you think that the doctors are also confused?
Liz: perhaps they are, I don't know
NP: what do you think?
Liz: I don't know if they are confused or what or hiding something
NP: mmm huh
Liz: from me, I don't know
NP: do you think that they would hide something?
Liz: well I think in my thinking, I think a lot of them would hide something
NP: mmm
Liz: they wouldn't like you to really know what is damaged, you have got
NP: right, and what do you think they might be hiding?
Liz: well I don't really know
NP: no suspicions?
Liz: no, I mean they are honest and good doctors, I would say, but I think when you have had a heart attack or stroke or even that, I have had 3 strokes
NP: mmm
Liz: but heart attack, you don't know nothing do you?
NP: mmm

Liz: come on let's be honest, you don't know what is happening to you do ya? but are they only saying it, I do not know, but when I had the head scan done here, they said that it was my left side that's gone dead
NP: mmm
Liz: and I turned round and said "would it come back again?"
NP: mmm
Liz: he said, "we don't know" and that is all he told me
NP: right ok and what do you mean by dead, that the left side is dead, what do you mean?
Liz: well nothing is going there
NP: mmm
Liz: it means nothing to read, nothing is going there, people will say things to me and I block it out
NP: mmm
Liz: then I got to say "you better write it down and stick it on the fridge," you know, I am getting very confused
NP: mmm
Liz: with everything now
NP: and when you say that the left side is dead, do you mean the whole of the left side or just a part of it?
Liz: I don't know they have never said
NP: and when you say dead, you mean um
Liz: dead completely!
NP: so not living
Liz: no, like me [laughs]
NP: [laughs]
Liz: no all jokes aside I hate to think I am walking around with half a brain not working
NP: mmm
Liz: is that what you sometimes feel?
NP: yeah
Liz: yeah cos I have never been the one to sort of like worry about things, I am not the worrying type, I just like to get on with things. If I am having an argument with anybody I have an argument
NP: mmm
Liz: but now I am getting terrible
NP: mmm
Liz: I want to hit everybody, I have never been like that in my life. If anybody touches my kids, I swing em!
NP: mmm
Liz: and I shouldn't be like that.
NP: do other people understand what you are experiencing?
Liz: I haven't told everybody
NP: but people that you have told
Liz: yeah
NP: do they understand what you experiencing, what you are going through?
Liz: no they don't! in one thing, they don't believe me
NP: mmm
Liz: and in another time, they would believe me
NP: mmm
Liz: they ask me about these people in your house, where do they go? I said "I don't know"
NP: mmm
Liz: you tell em to get out and they are gone, where do they go to? All the windows are shut, doors are shut, so they have got to have a place to go through, surely?

NP: what do you do to try and explain to people about what you are going through? What do you tell them?

Liz: I try to sit there and tell em what it was like when I had my heart attack, I phoned my daughter at 11 o clock at night and told her I am not here for much longer sort of thing, but they brought me out of it, I didn't know a thing

NP: mmm

Liz: and the first thing, I know what I did do was my daughter told me, I jumped out of bed and when I looked out of the window there was all these old fashioned houses

NP: mmm

Liz: down the side street,

NP: mmm

Liz: facing the hospital, the ward that I was in

NP: mmm

Liz: and there was this kid laying in the road

NP: mmm

Liz: aah outside the hospital, and my daughter said "there wasn't no child," I said "there was"

NP: mmm

Liz: "someone just run him over"

NP: mmm

Liz: and I wanted to jump out the window

NP: mmm

Liz: to pick him up

NP: mmm

Liz: so what was all that? And I remember this house, it had a black street door and as you opened this street door you must have been in the living room, it was all red furniture and she had a black and white cat. It was so big I couldn't believe it.

NP: mmm

Liz: but my family couldn't see it

NP: and you could see all this through the hospital window

Liz: yeah

NP: you could see into the living room

Liz: yeah, it was funny

NP: yeah

Liz: but my kids couldn't see it

NP: mmm

Liz: and I remember this, it must have been a porter or something

NP: mmm

Liz: he had a black suit on, rolled up shirt with like a little lip, not so as long as yours

NP: mmm

Liz: pointed

NP: mmm

Liz: with a big belly on him like Churchill

NP: mmm

Liz: but it wasn't Churchill he had grey hair and he was little and he was carrying a tray or something he had in his hand. My kids said "no there is no one there"

NP: right

Liz: and I was describing the people in that house

NP: and so when you are trying to get people to understand what you are experiencing

Liz: no one believes me

NP: no one believes you

Liz: no
NP: what does that feel like?
Liz: it feels nasty; it makes you feel you're a liar
NP: mmm huh
Liz: a cheat, and I have never been that in my life, no, that it what it makes me, but when my daughter said there was nobody in that house, I said "yes there is"
NP: mmm
Liz: I said "look at that little boy on the floor," there is no boy down there
NP: do you believe them when they say that there is nothing there
Liz: no, I still didn't believe my kids
NP: mmm
Liz: you can ask my daughter that yourself. No and I had nearly all my family there
NP: mmm but you didn't believe them
Liz: no
NP: and they didn't believe you
Liz: no so what do you do?
NP: mmm so what did you do?
Liz: I just went back in to bed
NP: mmm
Liz: I just said "I wanna go a sleep" and that's it
NP: mmm
Liz: and I come home a couple of weeks after
NP: and when you said I want to go to sleep you meant, you want to go to sleep or
Liz: sleep, proper sleep
NP: not the big sleep?
Liz: no
NP: when you say that you are seeing people and hearing laughter
Liz: mmm
NP: do you mean it just as you say it, that is exactly what it means?
Liz: yeah
NP: yes, so you are not sort of saying it in a different way
Liz: no
NP: to make sure, you are not meaning those things but in a different way
Liz: no
NP: so you are not saying it as if I am seeing it or something or
Liz: no
NP: it looks
Liz: I see em!
NP: mmm
Liz: I definitely see em!
NP: and when you say I am seeing something you need us to understand
Liz: it would be
NP: mmm
Liz: it would be nice for me to understand why they all started coming into my home
NP: mmm when you say it is like seeing and hearing laughter do you think of it as a metaphor, a metaphorical scene
Liz: it sounds like a joke
NP: mmm
Liz: to people, when I tell em
NP: mmm, do you mean it that way?
Liz: no I don't mean it that way, you get scared cos you don't know what people do mmm you know that you hear about it, but that is the only thing that I get worried about
NP: just in footsteps [???]

Liz: yeah
NP: um do you think that these experiences relate to, these things relate to experiences in your life, past or present life?
Liz: I, I wouldn't know, I wouldn't know, I can't swear on anything
NP: mmm
Liz: that is a question that I would not know. Funny that you saying that, someone said that to me a few weeks ago, is it the people that you know who have passed away come back to see you, I said no cos the people that I knew years ago died before I moved into this flat
NP: mmm
Liz: and there was only one man in my flat and that was him
NP: mmm
Liz: so where did it all come from? I don't know. but whilst I can explain what they were wearing, how can I do that, what the bike was like
NP: mmm
Liz: how he was sitting on the bike, cufflinks in his shirt
NP: mmm
Liz: how can I explain all that?
NP: do you think that, that relates to anything in the past
Liz: no! no
NP: the bike and the
Liz: no, not by me
NP: mmm so there is no obvious
Liz: no every person I see in my place I do not know. I don't know them
NP: other than your husband that first time
Liz: yeah, it is only him sort of thing but I mean he died what in 2013
NP: right
Liz: er 10 rather, beg your pardon, 2010 he died
NP: did he die before these things started to happen or after?
Liz: no after
NP: so he was with you when some of these things started to happen to you
Liz: no after he died it started to happen
NP: after he died
Liz: after he died
NP: so you didn't have any of these things before he died
Liz: never no
NP: so you had the heart attack after he died did you?
Liz: yeah
NP: do you think that your family or friends think that these experiences relate to something in your…
Liz: I don't know
NP: past?
Liz: I don't know we never talk about it
NP: you said somebody had spoken about well these could be people that you have known in the past
Liz: yeah that was years ago, but we don't talk about the past people who have died
NP: mmm
Liz: my family don't
NP: mmm
Liz: I mean I got 10 sisters and 1 brother
NP: yeah
Liz: and we don't talk about death
NP: mmm
Liz: we talk about life now
NP: mmm
Liz: how it has changed, how quick it has gone
NP: mmm

Liz: yeah, you get married, you have a family, where the babies have gone, they are grown up, you notice how the world is going round now
NP: mmm do you think that these experiences relate to what you have just said there
Liz: I don't know
NP: no
Liz: I don't know
NP: so not obviously
Liz: no. If I knew who it is I would have said but I can't see it me self
NP: mmm so other people seem to not understand what you are saying?
Liz: oh a load of people don't understand, and I suppose you don't even understand
NP: mmm
Liz: see everyone is different, you got your opinions and I have got mine
NP: mmm
Liz: and that is how it works
NP: mmm what is it like when people don't understand you?
Liz: I just walk off
NP: mmm
Liz: forget about it
NP: mmm
Liz: their turn has got to come
NP: mmm
Liz: that's all I say. Apart from that I don't care what people say
NP: mmm
Liz: I tell em and they believe me or not, I couldn't care less
NP: do you try to help them to understand
Liz: to be honest with you no, but they will only laugh at ya
NP: mmm
Liz: and people are gonna say I'm stupid
NP: mmm
Liz: no, I don't let, try to make them understand or nothing no
NP: why not?
Liz: because they will only stand and laugh
NP: mmm
Liz: and I don't like that because I have got a temper
NP: mmm
Liz: and I could do something dangerous
NP: mmm
Liz: I tell you
NP: mmm
Liz: no so that is why I don't talk about it to outsiders, it's alright you're a doctor I am talking to you, but I couldn't go home and tell em or sit around the table and say something, I couldn't tell em
NP: and why not, why couldn't you tell them about this
Liz: because they would laugh
NP: mmm
Liz: they would take the piss out of me and no I am not going to have that done
NP: mmm
Liz: and I would get myself in a state I'll start lashing out
NP: mmm
Liz: that is what I would do
NP: so you would get very angry
Liz: yeah it's me that has got to get it going properly
NP: mmm
Liz: nobody else, doctor, you and me, together
NP: mmm

Liz: to find out exactly what is wrong
NP: mmm do people ever seem to stop trying to listen to you
Liz: no, no, the only thing the only thing they will turn around and say is we don't want to know
NP: mmm
Liz: that is all they will say and I will say ok and they will just go off
NP: do people ever seem to ignore what you are saying?
Liz: some of them do
NP: mmm huh
Liz: not all, but some of them don't know, but you know, a few of them do
NP: but have you sort of told someone and then they are just you know ignoring what you are saying?
Liz: yeah, yeah they do, it is people like that out there
NP: mmm
Liz: you know you go to places for help and when you go home and say you have had a nice day he has listened and he has told you this, he has told you that
NP: mmm
Liz: they just sit there and laugh
NP: mmm
Liz: you must be a looney
NP: have people said that to you?
Liz: oh yeah, oh yeah. I have had it called to me so many times
NP: mmm
Liz: "you are round the bend." Oh ok, I'm round the bend
NP: mmm
Liz: then It won't be long before I am down there then will it
NP: mmm
Liz: that is just what I say to them
NP: mmm
Liz: but if they keep on, I say "well you better start running cos if I get you I will kill you"
NP: who says these things?
Liz: me
NP: no, sorry, I mean who says these things like you are a looney?
Liz: oh, people round here say
NP: right
Liz: they are a bit mental their self; so er you dare not look at them
NP: mmm
Liz: cos they will ask you what you are looking at, so I keep away from these sort of people
NP: right
Liz: I keep myself to myself. If I see me friends come over
[Phone rings] oh excuse me a minute
NP: right
Liz: oh what did I do with it?
NP: oh right yes
Liz: she moved down there from London, and I really miss her [laughs]
NP: sorry, you will get to speak to her soon
Liz: yeah that's alright
NP: um yeah so you were saying that some people have said that you a looney for having these sorts of experiences
Liz: yeah, yeah but I turn round and say to them "have you ever had it?"
NP: mmm
Liz: one day you will most probably have one
NP: mmm
Liz: and when it comes to your turn you will be thinking about what I said to you

NP: mmm
Liz: everyone is different, I know
NP: so do the doctors always listen to you and understand
Liz: I don't talk to doctors
NP: no
Liz: no [laughs]
NP: you don't tell the doctors about it
Liz: no
NP: but you told Professor Kopelman about it?
Liz: yeah
NP: and his team
Liz: yeah because I have known him all this time
NP: right
Liz: coming here
NP: ok
Liz: you know what I mean
NP: mmm
Liz: so I trust him
NP: so you wouldn't tell your GP
Liz: no
NP: about what is going on
Liz: no
NP: why not?
Liz: because I don't like my GP, I don't go down there, for anything
NP: mmm would you tell the, um are you worried about what the doctors might think?
Liz: in one way yeah
NP: mmm
Liz: you know, that is the only thing what puzzles me. If you go down to the doctors surgery and you are telling him about your life history, what is he going to say? He can't do nothing.
NP: mmm
Liz: it's like you
NP: mmm
Liz: he is a lot different to what you are, I don't like my doctor
NP: mmm
Liz: what he done to me last year when my doctor retired and he took over, and my doctor before he retired sent me a letter
NP: mmm
Liz: to go down and see him
NP: mmm
Liz: because he wanted to talk about my blood sugar
NP: mmm
Liz: and everything, so I went down there, I made an appointment and went down there and I had to see this other doctor. So I said "I have got a letter that I have got to hand in because er he has left." He said, "I've got all these patients outside that I have to see too"
NP: mmm
Liz: so I said "yeah, I have got a letter to see the doctor"
NP: mmm
Liz: and he said "well I can't see you" and I have never been there since
NP: so you wouldn't tell that doctor?
Liz: no, I wouldn't talk to that doctor
NP: yeah ok
Liz: I'm sorry
NP: that's ok
Liz: that's that way I am, I would rather be open than

NP: ok
Liz: well, I can't keep my mouth, that is not me
NP: [laughs]
Liz: I won't go down there, even my doctors in the ward I was in last week said go to your GP. I said what for, I don't go the GP's I have the nurses in the morning and in the evenings
NP: right
Liz: they give me my injections
NP: oh right, so do you ever tell the nurses about these things?
Liz: no I wonder what they would do if I told them, they haven't even got time to sit and listen to you
NP: right that is true
Liz: so what is the point?
NP: when you have told people about these things, do the people respond the way that you want them to
Liz: some, til they hear the full story
NP: mmm
Liz: and then they will say "you are going loopy," that is what they will turn around and say, so I say "alright, forget it"
NP: what do you mean by loopy? What does that mean?
Liz: mental
NP: so what does that mean? If you see what I mean?
Liz: mental, well it means to me in my books, mental means that you are going off your rocket… mental
NP: mmm huh so how would you know if someone was
Liz: I wouldn't know who is mental and who aint
NP: you wouldn't
Liz: no, well I do know a couple who live just facing me in the er, er, what do you call it dry, dry house
NP: like a hostel
Liz: alcoholics
NP: ok,
Liz: and they walk around in their pyjamas, through the parks
NP: ok so it is like a
Liz: what do you call it?
NP: rehab kind of hostel
Liz: yeah and they are always looking at me every day and I have to come in and shut my door, cos they will stand there and look
NP: mmm
Liz: oh they make me laugh, [laughs] they are not nasty
NP: mmm
Liz: you know what I mean, they want to be a friend to you
NP: mmm
Liz: but I wouldn't have them as a friend [laughs]
NP: [laughs] why not?
Liz: no, it is cos of what they do when they go out
NP: mmm huh
Liz: they go round the streets looking for dog ends and that makes me feel like oh my God what are you doing?
NP: mmm
Liz: but I don't talk to none of them, they may go by and say "good morning, hi," and I say "morning"
NP: mmm
Liz: no don't invite them in cos they will send you mad [laughs] but I wouldn't hurt them
NP: mmm
Liz: because I mean they are alcoholics
NP: mmm

Liz: you can't blame them, that is all they have got in life, that is it
NP: ok, um do people always respond how you want them to, to what you say?
Liz: well we don't always talk about it
NP: mmm
Liz: they may say to me, if I see them around, "how are you, any better?" and I say "yeah, yeah, you know"
NP: mmm
Liz: that's all I say, I don't say no more now
NP: mmm
Liz: that is how I go
NP: what do you understand about the visuals and the hearing things?
Liz: I don't know. I am trying to work it out myself, why it has just started sort of thing, in 5 years, why?
NP: people call them, psychiatrists call them hallucinations
Liz: yeah they do don't they, yeah I remember him using that word.
NP: do you understand what that means?
Liz: no I don't, you tell me
NP: well a hallucination is somebody perceiving something that isn't really out there in the world, so hearing a voice when there is no voice
Liz: yeah
NP: seeing a person when there is nobody there
Liz: so it is me then?
NP: that is how we would see it
Liz: see it yeah
NP: what do you make of that?
Liz: I don't know, I don't know. Anything can be done?
NP: um would it be better if it is you or would it be better if it is
Liz: no, if it is me
NP: mmm what I mean is would you rather that the explanation was
Liz: yeah, yeah
NP: that there was something going wrong or would you rather that the explanation was
Liz: I would rather the truth
NP: that there are people and the dolls are laughing
Liz: yeah
NP: which one, which one is better if you see what I mean
Liz: the first
NP: that the problem lies with you
Liz: yeah
NP: you would find that a better explanation
Liz: mmm
NP: why do you think that?
Liz: I don't know, I think that it would be a lot of answers said to me about it
NP: mmm
[loud noise from corridor outside]
Liz: someone is trying to come in
NP: it is just another door I think
Liz: [laughs] its creepy
NP: [laughs]
Liz: no I think it is what I want to know myself
NP: mmm
Liz: if someone has got the guts in them to come and tell me actually what is wrong with this part of the brain
NP: mmm
Liz: I think that I would be more happier
NP: mmm
Liz: to know

NP: right
Liz: than not at all
NP: yeah, so you would find it better to have that as an explanation
Liz: mmm
NP: why would that be a better explanation for you?
Liz: it would help, it would help me to do what I want to do, help me to relax and sleep properly, without having all these noise and laughter, that is what it will do to me
NP: what about if they said, well we think it is to do with this part of the brain being affected by the stroke or the heart attack, but there is nothing we can do about it
Liz: well then I would just have to live with it
NP: would that be better than, would that be a better explanation than
Liz: it would in one way, but I would like to know if they could give me a tablet or something to take
NP: mmm
Liz: to stop having all these things coming towards me or dolls laughing, people laughing, yeah
NP: you mentioned that you feel that people would laugh at you about these experiences
Liz: yeah
NP: but you have also said that the dolls are laughing at you
Liz: yeah
NP: do you think that, that is related, that you worry that people laugh at you
Liz: maybe, most probably. I don't know
NP: is that something that you have had going through your life, worry that people will laugh at you?
Liz: no, I have never had a life like that. I had a good life because I was brought up in the salvation army
NP: mmm
Liz: when I was a 5 year old kid
NP: when you were a young adult or
Liz: no, child
NP:` yeah child, did you worry that people laughed at you
Liz: no, cos I used to stand up in [laughs] Peckham Rye and ring tambourines every Sunday
NP: mmm
Liz: used to go Church, yeah, they were the good old days cos I wasn't wanted when I was a child
NP: mmm
Liz: so I was brought up in a Convent until I was a certain age to go and live with the Salvation Army
NP: did you ever meet your biological mum?
Liz: yeah but she didn't want to know. I went to her funeral
NP: mmm
Liz: oh yes, she has been gone what 20, about 22 years now with my dad, mmm
NP: and did you
Liz: I never found out why she dumped me or anything
NP: mmm
Liz: about the other sisters no, because they were older but they won't tell me nothing, I've asked
NP: so it was only you of the family that went with the
Liz: yeah, I was the black sheep
NP: mmm
Liz: mmm perhaps I wasn't her daughter

NP: mmm
Liz: I don't know, I don't know, she was 79 when she died
NP: mmm, aged 79
Liz: mmm
NP: yeah
Liz: she is up Pearly Cemetery
NP: do you think that any of that relates to those experiences
Liz: I don't know, I don't know, I hope not
NP: do you ever think about that?
Liz: no I don't to be honest, I never even thought about that to be honest
NP: mmm
Liz: me dad he was a good old stick, but he went mental
NP: mmm
Liz: cos he died at the age of 79, the day he died was the day he got his divorce from my mother
NP: mmm
Liz: she was evil in her younger days, but never mind, that is way of the world
NP: but it doesn't sound like you link these things up in any way, no?
Liz: no, I never thought of her
NP: how old are you now?
Liz: 74
NP: 74
Liz: mmm getting on now [laughs]
NP: what has it been like being interviewed about these things?
Liz: scary [laughs]
NP: [laughs] in what way?
Liz: ooh in a lot of ways really, it is scary, I mean you never know what is around the corner do you, you never know what is going to happen from day to day
NP: mmm
Liz: that is the way I look at it, I take day by day. If I fall on the floor tonight, I know what is going to happen.
NP: mmm
Liz: you know, life, but you still got to carry on, that is the way, thing I look at
NP: do you think that being interviewed about these things have been helpful in any way?
Liz: it has because I know that we are together talking about it
NP: mmm huh
Liz: and I know I aint going to go home and start talking about it
NP: mmm huh
Liz: what we said, we said, right
NP: mmm
Liz: you have been truthful to me and I have been truthful to you
NP: mmm
Liz: no need to lie, but I would like to know actually what is wrong
NP: mmm
Liz: cos I have never been like this
NP: have you found this interview upsetting?
Liz: in some bits but you have got to answer questions
NP: mmm huh
Liz: that is the way I look at it, if you don't try and help yourself who is going to help it
NP: mmm
Liz: you are the expert on it, I am not

NP: mmm
Liz: so I shall just go home and just think about all this
NP: mmm huh
Liz: that is what I will do.
NP: do you think that this interview has changed the way that you think about any of this?
Liz: yeah, in some ways yes. But I wouldn't go around telling people at home
NP: mmm
Liz: what my story was in here today
NP: but do you think that you understand this
Liz: I understand
NP: do you understand in a different way to before
Liz: yeah I do, I think I do now, I think I do pretty much yeah
NP: so what is your understanding now?
Liz: my understanding is I am not hearing nothing
NP: mmm huh
Liz: I'm not going to see nothing, that is my understanding is going to be, starting from tonight
NP: mmm
Liz: all my dolls and teddies and that have all been black bagged in my bedroom
NP: mmm huh
Liz: and I shall keep them there
NP: you will keep them there?
Liz: yeah and just see if I have a better night sleep
NP: mmm
Liz: without all this ooh, yeah
NP: yeah, well that is the end of the interview from my point of view
Liz: [laughs]
NP: [laughs] thank you very much for your great help, we ran over by 3 minutes so I hope you don't mind
Liz: ooh what
[End of Transcription]

J. JOHN'S TRANSCRIBED INTERVIEW

NP: I am just going to start recording now ok
John: ok
NP: Now that is us recording
John: yes
NP: now what, um so I have got some questions that I am going to ask you and you answer them exactly as you like
John: yes I will answer them the way I think, yeah
NP: exactly, now why are you in hospital at the moment, what is the reason why you are in hospital?
John: now that is a good question
NP: mmm
John: they say that I am sick, I don't feel sick, but they say that I am sick
NP: mmm
John: but they let me out
NP: mmm huh
John: now they must think I am sick again [laughs]
NP: mmm huh
John: I don't know
NP: right
John: my sister doesn't think that I am sick, maybe they think that I am sick up there
NP: right
John but I am not sick up there neither, cos I'm intelligent enough
NP: mmm huh
John: so as far as I know that is the way that they are going
NP: and what, what do you mean that they let you out, when did they let you out and why?
John: well they said "Mr M you can go home, or you can go home to your sisters," something like that, I don't know, but this is going back a long time um in London
NP: mmm huh
John: you know cos I mean I am as good as the next man as far as I am concerned
NP: mmm huh
John: I don't do anything wrong or anything, so it is just one of these things. I think it is people kind of drying up a lot you know
NP: kind of what?
John: follow the bandwagon, you know
NP: right
John: that is my inten… um… what I think. Now my sister doesn't think it
NP: mmm huh
John: she says maybe there is something wrong with you [laughs]
NP: mmm huh
John: I don't know
NP: yeah and when, when did they let you out of hospital?
John: well um I can't remember, well the whole point about it is my sister came down here to work
NP: mmm
John and I came down to um try to find her address, but I didn't, but I got to get her anyway
NP: mmm huh I will do afterwards yeah

John: and yesterday I was out where she worked, and she said “you can come and live with me” and so I said “thanks very much” and I can get to get my money to pay her you know
NP: yes
John: because she is a nice woman, so that is it
NP: and had you lived with her before
John: not much, not much, I was different places
NP: ahuh
John: I only got married once and she died and that’s it
NP: and where were you living before you came here
John: I was ok, I was near um I was always living in some place, but I can’t think what it was [laughs]
NP: right
John: but I remember her saying to me um she was working out in the… country and she says and she started laughing and she says “I might as well get you tidied up” and that was it
NP: mmm huh
John: so she said “you can come and live with me,” and um “I have got a flat is big enough for the two of us”
NP: mmm
John: in the town, wherever the town was
NP: mmm huh
John so I said that will be fine and I will be glad of it, and I haven’t seen her since.
NP: yeah
John: and that is how it is and that is only yesterday, but I am trying to phone her, you can phone her while you are here, I have her address right here
NP: right yes I will
John: so that is the story so far, so you can carry on now
NP: you mentioned to me the other day something odd happening with some cleaners in the city
John: yeah? I can’t remember, what here, in London here?
NP: yeah here
John: well I can’t remember now
NP: no ok
John: it probably was, um, you see sometimes I think things are bigger than what they are
NP: right
John: you know, but I went and had tests
NP: right
John: they told me to go back. Some people say…. My sister says that there is not a thing wrong with me
NP: right
John: it is just that I imagine
NP: right so what kind of things do you imagine?
John: well I think that shouldn’t be done or that’s done and this… you see I should be minding my own business [laughs]
NP: do you ever say that things have happened that other people say haven’t happened
John: no, to be quite honest I forget half the things that happen
NP: mmm
John: cos if I didn’t I would go fucking mental [laughs] honestly, but I am not
NP: mmm
John: I mean, I will give you an example, um I went or a head test, I think I told you didn’t I?
NP: mmm

John: in the hospital and the doctor said that they found nothing… so I am supposed to be bloody mental and I know that I am not mental
NP: mmm
John: everybody gets a bit of spasms now and again or whatever they might be, and my sister said you want to take it easy and this and that and whatever, so she said to me that she will come and live with me
NP: mmm ok, so what is your understanding of the problem, what is your understanding of why all of this is happening?
John: well the problem is… that is a good question [laughs] well it might take an hour or two to do it, I don't know, it seems like it'd be better off if I stayed in London and it'd be all under the carpet sort of thing
NP: mmm
John: and stuff like that
NP: mmm
John and she says come down, I have a home and so I come down and she says you can live here, and do what you want to do, go to work if you want to and that was fair you know, so I said I don't know whether to take me own work
NP: mmm
John: I can do all casual work or something you know in the farms
NP: yeah
John: so um I can draw me money, I hadn't even drawn it sort of thing [laughs]
NP: had you been working recently
John: no, I had been out with a fella there, in here now, he runs a kind of a thing
NP: mmm
John: he pays that in there look
NP: uh huh
John: he pays in the hand and that is no good
NP: right
John: I want it um thing, she said you don't need to work I, I, I, I got my, um I am on now what um a pension
NP: mmm
John: I could be getting my pension now, I should be getting it
NP: so had you been working for that guy out there [referring to someone on ward John had said was his "governor"]
John: I worked for him, um and um he is there now
NP: uh huh
John: but my sister works for him so who am I to um
NP: and what, what have you done
John: bugger all [laughs] I was doing um bits of jobs [laughs] in the country out there
NP: mmm
John: he's alright, he's got a place in the country out there, he makes money
NP: mmm
John: out of other people, he shook his head, anyway I don't [inaudible] I tell the truth
NP: mmm
John: if he doesn't like it he can lump it
NP: right
John: so did things end badly between you two?
NP: um no he came down and he was talking to me sort a thing, like my sister came to the yard yesterday
John: mmm
NP: and she said "you will be alright with me" blah, blah, blah and he said "ok" and I was supposed to meet him and I finished up here out in the country and another place all together
John: right, I don't know, I don't know

NP: [laughs] and how did that happen
John: oh don't ask me
NP: you don't remember?
John: I don't remember a thing
NP: right
John: but I remember when she talks or somebody like you who are important I can remember things like that, but I can't, so maybe um maybe there is um something wrong, I don't know, maybe I should go on um but the hospital they examined me and they took a head thing
NP: mmm
John and I don't know whether it is good, bad or indifferent, they never told me
NP: right
John: you could find out
NP: mmm yes I will, um, you mentioned that you couldn't remember what happened yesterday. Do you feel that you have got problems with the memory?
John: well, um, um I think I must have, I am old enough to have it now I suppose but the whole point about it is, I know that she said to me, um, this is what she said um "you come to me whether it is today or something and you will have your own room" that is it dah, dah, dah I said ok because I get my money anyway
NP: mmm
John: she doesn't have to feed me and it works out alright, so whatever happened I finished back here
NP: mmm
John: and I can't think of it
NP: you can't remember
John: I finished up in the man's house [referring to HCA on the ward who he believes is a farmer] and he started dictating to me and I wouldn't have it
NP: right
John: no I wouldn't have it, so he said well, I was getting up to go and he says "ok stay the night," and I don't know whether I stayed in it or I didn't, but he didn't do much for me anyway
NP: right
John: but he is the one that pays the wages to her you see
NP: and so would you say that because um so this problem with the memory do you ever sort of fill in the gaps yourself if you like?
John: no I never looked into it so much because it didn't affect me
NP: mmm
John cos I don't tell lies, I don't have to
NP: mmm
John: other people can tell them, I go away and laugh because it doesn't bother me
NP: mmm
John: but um I mean what can you do? um if somebody tells you something you think it's true, or vice versa. I mean, I never bothered, I was always kinda truthful, and she knows that my sister, so the whole point about is, I don't know what is wrong, I don't think that there is much more um they took a scan of this
NP: mmm
John: I haven't heard the result
NP: mmm
John: you could find out that
NP: yes

John: I don't think that there is much wrong, well they might say there is bits, but there is bits in everybody
NP: right
John: but I don't go round bothering people telling lies or anything. I don't know there may something there but I don't know about it
NP: do you worry that there might be something there?
John: course I do, its natural
NP: mmm
John: but if it is there it doesn't affect my life really, if you live in a nice um family or whatever or your sister or whatever um doing your thing, you can go to work with her or do what you do, and life goes on a bit better you know
NP: mmm
John but um I don't know myself, my sister she says there isn't much wrong with you [laughs] don't ask me
NP: do you feel that there is a problem, I mean deep down do you feel that there is a problem?
John: um I feel there could be a problem, but I don't know, I can struggle with myself in a way, I go to work if there is work, I can draw my money, which I haven't drawn at all now
NP: ah huh
John: and I can use the money to the best of my advantage, I don't drink, I don't smoke
NP: mmm
John: I stopped, so I think that it is a good slope for me
NP: mmm
John: she will tell you more than me. Do you know her?
NP: I tried to er speak to her the other day
John: yeah cos she is at home now, I can't think of the bloody number
NP: mmm
John: but she doesn't know where I am, so if you [inaudible] tell her where I am
NP: mmm
John: you see because she wants me to come home
NP: but did you not say that she saw you yesterday?
John: she seen me yesterday but not since
NP: right
John he buggered it up [looking through window in door at an HCA in corridor]
NP: right what, what did he do?
John: well first he said "you can stay the night" and then he said "no, blah, blah, blah, blah," so fuck it, [laughs] if you want me out I will go out you know
NP: and when he said
John: do you know where I stayed?
NP: yes
John: where?
NP: um…
John: they were a lovely family
NP: ah, who was that?
John: um the, the, the, um the, the, young person, ah, ah, um, me breakfast and everything for nothing
NP: mmm
John: lovely, fond
NP: right
John: I can't think of their religion, but I left there this morning
NP: and what are their names?

John: I can't think of their names, the lad was a tall, thin fella and they give you like food in it
NP: mmm
John kind of like, um, they were nice people anyway, there was other people coming in there as well
NP: mmm
John: you know, the boy is a big lad and he was telling me what happened and this, you know, there was two people um sitting there in the sitting room [sounds like a description of the ward bay]
NP: mmm
John: so I deal with it the best I can yeah
NP: and what kind of a place is this?
John: well it is an ordinary house, um they have a 3 people or something it's kind of like a restaurant come whatever, that is what I think so
NP: right
John: and the lad told me yesterday, um last night, he took me in and he was very nice, cos I had no place
NP: right
John: and I thought to myself God and he gave me breakfast this morning, you know, but he gave everyone breakfast, but I thought it's the only free meal around here [laughs]
NP: right
John: I don't normally do it honestly
NP: so how long can you stay there for?
John: well I don't think that it is very long ah, um um, to be honest I don't want to stay there long, I want to go to my sisters
NP: mmm
John: or go back to London
NP: mmm
John but she says come and stay with me
NP: yes
John: and I would be happy you know
NP: do you know where she lives?
John: no that that, is the point, she lives… she give me the address, but I just can't think of it. She give me the address [laughs] she lives somewhere in the um not far from where she works I think, not far, I'm not sure. He would know
NP: right
John: what's his name?
NP: how would he know?
John: cos she works for him, you see
NP: right
John: she works for him, she is working for him, but it's a different kind of work, it's a day work something like that
NP: right, do you know the details of that?
John: well all I know is that she works there, I, I, I, I, I, don't know, there he is, some sort of a farmer but he doesn't farm himself. I was in the house, I fell out with him
NP: what was that over?
John: well um it was over he wanted to dictate to me and I said no
NP: he wanted to what?
John: dictating what I do and he said "well you can do this" and everything and I said "show me the road," [laughs] no I wouldn't
NP: mmm
John I wanted to go to London, but I couldn't get to it, so he said he would contact my sister
NP: mmm
John: you see then she would come and take me you see

NP: mmm
John: crafty, he is a crafty bloke
NP: right
John: he is one of the old timers, people working for fuck all to be quite honest, in my opinion
NP: mmm
John: he is looking at books in there now
NP: mmm
John: I wouldn't trust him as far as I would throw him [laughs]
NP: you wouldn't what?
John: I wouldn't trust him as far as I would throw him, but [inaudible] you might stay the night an all, he says that
NP: right, so it does sound like sometimes you can't remember everything
John: oh yes, it comes so quick to me
NP: mmm
John: you see my sister laughs at me, but that is just the way it is
NP: and when did you notice that this was a problem?
John I didn't notice it at all much you know, he is lip reading [laughs, looking again at HCA]
NP: mmm
John: I'm terrible [laughs] I hate people, honestly, he is one of them people I don't like
NP: right
John: you know I am sorry, but he is one of them people who… he has a big place
NP: mmm
John: and he is the big kiddie in it you know
NP: mmm
John: he said "you can stay here the night, as long as you want, providing you tow the line"
NP: right [laughs]
John: [inaudible] [laughs] yeah he is laughing, I don't give fuck all about him, I tell him to his face
NP: mmm
John: one thing my er grandmother used to say "tell him straight what it is"
NP: mmm
John: anyway
NP: so when did you first notice that you were having problems
John: er other people noticed it
NP: yeah
John other people noticed it, yeah
NP: you didn't notice it?
John: I went and got a head thing done, now this is another thing, I had it done down here
NP: mmm
John: I haven't got the results yet
NP: mmm
John: and I think, my sister says "there isn't much wrong with you," but they all say that, but there might be something, there must be, I can't, maybe I can't control it
NP: mmm
John: but I don't know about it
NP: right
John: if I knew about it I'd go for treatment
NP: yeah, so do people tell you that you have trouble with your memory?
John: well my sister says, um yesterday she says "your memory"
NP: mmm

John: and I said it probably is, and she could get me into a hospital and get me examined, better than going from one to the other, and if they say you need this or you need that then I will do it, but um she is the woman that can work it

NP: yeah

John: so she says come and live with her, she has got her own place and this, that and the other and all I have to do is whatever, and we do get on

NP: mmm

John but em I don't mind about the whole situation, you're doing your best and something happens and you get mixed up and your brain gets mixed up and people say "God there is something wrong with that fella"

NP: right

John: and maybe yeah

NP: so it sounds like maybe you do feel mixed up sometimes

John: oh of course I get mixed up, most people do

NP: mmm

John: but you come out here, I'm sorry I did come out, she said come out, or come down or whatever it was and I came down and I thought it would be a change

NP: so do you get mixed up just as much as other people?

John: I probably do more [laughs]

NP: you think more?

John: yeah, but I retaliate you see

NP: right

John: I retaliate, I hate people mocking me, and that is the way it is. I hate a bloke like him

NP: mmm

John: swaggering along, I'm the kiddie you know, if you don't fucking like it you can fuck off

NP: and have you always hated that?

John: well I stood up for my rights

NP: mmm

John and I think people are entitled to

NP: mmm

John: if you don't, then they will walk all over you, but then again you can overdo it I suppose, but that is the way that life is

NP: my understanding is that the doctors have said there is some trouble with the memory and that actually because of the trouble with the memory you fill in the gaps if you like with stories

John: could do, I won't disagree on it, yeah, I probably need help

NP: but what do you think of, do you think that it is true that you fill in the memory gaps with stories

John: I probably could, I probably could unknown to myself, but I wouldn't do it purposefully

NP: no

John: no, that is the truth, I wouldn't do it purposefully

NP: right

John: I probably talk, like I am talking now

NP: mmm

John: and other times I wouldn't do it that way at all [laughs] I would just say fuck it, I am not having this and turn and walk out

NP: what do you think of that as an explanation for some of your troubles

John: um

NP: do you think

John: it's the easy way out I suppose, to walk away from it

NP: mmm

John but I am all for a [inaudible] if I have got something wrong there

NP: mmm

John: and people can cure me or something [inaudible]. No, I wouldn't like working for that fella [looking at HCA again]
NP: mmm do you think that you do fill in the memory gaps
John: I probably do, I am not saying that I do, but
NP: mmm
John: I want the man to come along and I have seen them and say now look Mr M, I've got this, this and this about you and put it on the line
NP: mmm
John: I'm not going to run away
NP: mmm
John: and say look you need certain things and you have got to follow the rules
NP: mmm
John: and there is rules but there are things that you can't stop I suppose
NP: mmm
John: my sister says I'm alright with her, we might have a little bit of arguments, but everyone has bits of arguments, what can you do?
NP: so do you think that this explanation you have got memory problems and you fill in the gaps so you think that it applies to you?
John: it probably does, but I haven't heard the results of this
NP: right
John and it is in the hospital and they done it
NP: right
John: they come and say Mr Maguire you have got problems
NP: mmm huh
John: ok
NP: yeah
John: but if there isn't
NP: mmm huh
John: you are going to go the other way aren't you
NP: yes
John: anyone would
NP: so if they said that there are problems, would that make you a bit, would that make you think actually some of these things aren't actually not true
John: no I would say if they find out there is a problem, I would find out and I would go with it, they have things that I haven't got
NP: mmm
John: and can read your mind or whatever it is, yes as long as it doesn't interfere with my life to a certain stage that I will be able to cope, because remember I am going to go and live with her
NP: mmm huh
John: and she is good
NP: yeah
John so
NP: do people understand
John: I don't, sorry go on
NP: or believe what you say
John: I don't know and I haven't a clue to be quite honest with you because I don't mention it much
NP: mmm
John: because don't want you talking about yourself [laughs]
NP: mmm
John: they will think that you are a bloody nutter or something. The only one you can talk to is the psychiatrist, somebody who understands it
NP: mmm huh
John: and then you can get it done and you go and see your family or whoever they are you can say "look this is my problem

NP: mmm
John: and you have got to live with it"
NP: right and do you feel that you do have a problem, a psychiatric problem
John: yes I must have, I must have something
NP: right
John: but I don't feel it in my head
NP: yes
John now that is another thing, they done that in the hospital and I never got the result
NP: mmm
John: I never got it
NP: yeah so you are waiting for that
John: [laughs] well, I would be mad not to get it [laughs] you know, I must be out my bloody minds, you know what she says? "there is fuck all wrong with you" [laughs]
NP: she said that? [laughs]
John: yeah, but she would say that
NP: do you think that other people understand what you are experiencing?
John: I don't think so, no I don't. You see I am a kind of a person a lot builds up in my mind
NP: mmm huh
John: and sometimes it goes, it takes over and sometimes it doesn't
NP: mmm huh
John: like, I cannot stand a pile of people giving it all this, I walk away from it, I don't want to know it
NP: mmm huh
John: and women as well, I mean I'm not a man who boasts about my doings or anything, I can't afford to be, cos if I'm not right in the head [laughs] but most of my life I did alright, you see, most of my life I have not had any complaints or nothing, my wife never had any complaints about me doing anything, she used to say "just slow down, take your time working" you know, but that's all
NP: mmm huh
John: but it can come on you, this thing I suppose, it can come on you in later life
NP: mmm huh
John well you would must understand it
NP: mmm
John: well I am only talking as a nutter [laughs] you see, but I think to myself saying these words to you now, I don't suppose, well even my sister said you can carry on with life can't you, and that's what it is all about isn't it
NP: yeah
John: as long as you don't interfere in other people's business
NP: mmm
John: and that's it
NP: mmm
John: I mean the psychiatrist, they will know everything about you
NP: yeah
John: and if they printed everything they know about you, then you'll be in prison [laughs]
NP: right [laughs]
John: it's true
NP: right
John: but I don't go around hurting anyone
NP: which psychiatrist will know everything about you?

John what the fuck would I know [laughs] one is the same as the other [laughs] I don't know, I never had any dealings with psychiatrists or anything

NP: mmm

John: I mean when I was a young man nobody even talked about fucking going mad [laughs]

NP: mmm

John: honestly, I was over in Ireland working and then came over here. I never had any problems, I knew what I was doing and got married, blah, blah, blah, that is what everybody does when they are in love

NP: mmm

John: I had a few pints, I don't know, honestly I couldn't put my, if I sat here and said I am 100%, I can't do that

NP: mmm yeah has anything unusual happened to you recently

John: not much really [laughs] only coming down to this section down here

NP: mmm

John: even in London, I got used to doing the same old thing, but you get bored of it too

NP: mmm

John: it's your home and then she moves down here and she says, "you move down, its company for me" and then finally I move down [laughs] and then the psychiatrists start, she knows about it

NP: yeah

John: did you talk to her?

NP: not yet I have tried but I will speak to her

John she knows about it, you see she will probably tell you, maybe there is something wrong with me, I don't know

NP: mmm

John: but I go with it as long as they don't lock me up [laughs]

NP: mmm

John: and I don't think I deserve it [laughs]

NP: but when you were in London, I think you told me about something that happened with the police

John: oh yeah, what was that? I can't think about the police now, what was it, give me a, did the police pick me up? My sister told me

NP: right ok

John: ah right yeah, I went missing, drunk

NP: right

John: I got drunk and went missing, I don't fucking know where I was and the police found me way out in Highgate and now I live in Aldgate [laughs] so I don't remember them there, I don't remember them talking to me, and they landed me back, they must have found out where I lived anyway, and they landed me back to my sister and to talk to this that and the other

NP: mmm

John: and they said, um this fella is looking in here all the time [referring again to HCA], and they said um they picked me up

NP: mmm

John: I didn't know where I was

NP: mmm

John but that happens to a lot of people, maybe it was something to do with that, I don't know, and the drink

NP: mmm

John: and the drink, they are blaming the drink. Well if they are blaming the drink, it's the drink [laughs] and my sister says, "you see now what you've done" [laughs]

NP: and where did you go?

John: somewhere up near Highgate

NP: mmm

John: it's a long way out, well I, but how did you get out there? Got a lift maybe, I don't know

NP: mmm so you can't remember the details

John: course I can't remember, so she says to me, "look what you done, look what you done now," I must have walked it or maybe got a lift, I don't know, then another time I got a job in a place in the um, big um what do you call it um in London um the big um where they deal with all the money the big um what's it call, um the stock exchange, I knew everything about it, I knew where to work and all this, but I had a couple of pints and boom [laughs]

NP: what happened [laughs]

John: [inaudible] [laughs] my sister would tell you better than I would, because I forget

NP: right

John: I don't even remember

NP: this is what happened in the stock exchange is it?

John: yeah, yeah the stock exchange [laughs], you see these two women they were cleaners and they come in and I am sitting there in front of the television, and they say "John are you working?" you see I get a bit of work now and again and I am waiting here and somebody says I'll give you a job, she is a cleaner, you sit down and we will call you. It was the biggest con you have ever seen in all your living life

NP: mmm

John I am sitting there 3 to 4 hours, they locked the door and fucked off when they done their cleaning, lucky enough I got out

NP: how did you do that?

John: because one of the doors had the key on the inside

NP: mmm

John: so I walked away down [inaudible] street and instead of going home, I went the other way, cos I had a few drinks when I was waiting for the girls to call me to do or help with the cleaning

NP: mmm

John: and [coughs] I finished off I don't know where but it was way out 3 or 4 miles outside of London and the police came and picked me up and brought me home

NP: mmm

John: and you want to hear the commotion, [sister saying] "look at the police coming and pick you up," I says I don't remember them picking me up, if you didn't fucking go out [laughs] you would not be in that mess there. It was the drink versus whatever that day

NP: right

John: and that is it and eh I didn't know where I was or where I was going

NP: mmm

John: but they conned me you see with the cleaning job

NP: mmm

John: but that is the way people are, they blame you anyway

NP: what do you mean it was a con?

John well they brought me in and told me to sit down for 5 hours

NP: mmm

John: and they were cleaning themselves, I could hear them

NP: mmm

John: in this office and I could hear them go quiet and they went out and locked the fucking doors and left me in it

NP: mmm

John: lucky enough it was one door and I got out

NP: mmm

John: and the police said “why did they do it?” and I said “I don’t know.” They didn’t want to pay me because I didn’t do nothing anyway
NP: mmm
John: but they said “we do need you,” but they didn’t
NP: mmm
John: I know the woman well
NP: mmm
John: so that is the way it was
NP: and where is she now
John: she is still doing her job in the stock exchange
NP: mmm
John they’re doing their cleaning, but why didn’t they tell me they had no work, they told me to sit down for 4 or 5 hours
NP: mmm
John: it takes them 6 hours and they slipped out and left me in it, I could have been arrested for breaking and entry
NP: mmm and did they forget about you?
John: nah, they left me
NP: and why did they do that, why would they do that?
John: because they didn’t want they uh, uh uh, um, they promised me a job and they backed out
NP: mmm
John: my sister went mad
NP: mmm
John: but I got home, with the help of the police [laughs]
NP: right
John: I was way out somewhere in fucking Highgate, that’s a long way
NP: so was it once or is it twice you have sort of gone missing
John: twice
NP: right
John but that one, it wasn’t my fault
NP: right
John: what can you do? That, that is a good one, put that in the book [laughs]
NP: When you tell us these things, I mean is it, do you mean it just as you say it, this happened exactly as you mean it
John: yes exactly it happened, it happened
NP: mmm yeah
John: yeah a lot of people won’t want to realise people do it
NP: mmm
John: to you, I mean all she had to say was “John I’m sorry I don’t have any work for you go home”
NP: mmm
John: but sit there she says you can watch some telly
NP: mmm
John: and they go and leave me and lock the doors, lucky they missed one, well I would have pressed the alarm anyway
NP: mmm
John: cos I know I didn’t rob anything or do anything
NP: mmm
John and the police even said it, they could arrest them for it
NP: yeah
John: but they didn’t [coughs] my sister and the woman are friends, but I told my sister they are cons
NP: mmm
John: bring a person in and getting mixed up with it you know, but that is the story anyway
NP: what if I said to you know the guy who you have seen here who walks past he actually works in a hospital and he is a healthcare assistant

John: in a hospital and he lives in it and the whole family lives in it
NP: and this is a hospital here
John: and this is a hospital, it's nearly all hospitals [laughs] wherever you go [laughs], I am telling you, I got the shock of my life
NP: so um what do you think of that, that actually he is not a farmer he is actually one of the nurses here
John: well he seems to be, uh, uh, he is everything
NP: mmm
John: he is a bit of a … [laughs] but anyway it is not for me to say
NP: but what I mean is your sister does not work for him and he is just one of the nurses that work here
John: she does work for him, she works for him, he is the kiddie
NP: he is the what?
John he is the boss
NP: right
John: she works for him, not her all alone
NP: so you are quite convinced of that
John: well I am nearly certain sure of it
NP: mmm
John: she goes to him and blah, blah, blah
NP: what do you think of it when I say actually he is a nurse and your sister doesn't work for him
John: well then I don't know who she works for
NP: mmm
John: well that is all I can say to that
NP: mmm
John: but does she know? That is all I know
NP: mmm
John: well it is none of my business really where she gets her wages, but he seems to be in charge
NP: so it sounds like you are pretty convinced that she works for him
John well she told me she did
NP: mmm
John: I don't know, maybe he pays her wages through somebody else, I don't know
NP: mmm
John: what the situation is but he, he, me and him had an argument out at the house and I said "I want to go home"
NP: mmm
John: and that was only day before yesterday, and he says I am not going to, which is right, he is not going to give me the money to go home, so I said "well," but you can stay here the night
NP: mmm
John: I don't know whether I stayed or not
NP: do you think that these experiences that you are having, these sort of thoughts that you are having do they relate to anything from your past
John: well they could do but if he is in the middle of the person and you are having a bit of a discussion or an argument, it must happen
NP: mmm
John: you know
NP: but what I mean does he remind you of anyone from the past, is he like anyone you have known in the past
John: well not really. I did come up against that when you are a young man when you are out in the country farming. I was a milk man [laughs] I worked for a dairy farmer and milked 25 cows, which was a lot of cows, me and him and his wife and he was a sick man and I milked and delivered and worked on the land as well. I got a wage and that was it

NP: so does he remind you of any of those farmers
John this fella
NP: yes
John: he is too thick for a farmer [laughs]
NP: he is too?
John: he is too fucking thick [laughs]
NP: right [laughs]
John: I am telling you the truth he is [inaudible] whatever it is he is, I wouldn't work for that for 5 minutes, because you would be doing it his way
NP: does he physically look like one of the farmers?
John: indeed he does, he does, a thick one an all [laughs]
NP: a thick one
John: that's the way I am
NP: right um
John: my sister says "don't go near him again," but she works for him and she gets her money
NP: yeah
John: so that's alright um I am not going to
NP: and have you had any arguments with people like farmers and things in the past?
John oh [inaudible] I knew the man that I was working for
NP: mmm
John: I worked for him and if I worked for him I would look after him
NP: mmm
John: sell his milk and deliver it and um that is what I am paid for
NP: mmm
John: and that was the way it was
NP: mmm
John: till I came over here and started working for big firms
NP: mmm
John: I mean I had, I don't think I ever had trouble with most people
NP: mmm
John: I would sooner walk away
NP: yes
John: honestly I would, I would sooner walk away and my sister even says today you usually walk away
NP: yes
John but sometimes you can't [laughs]
NP: have you been finding that you are less likely to walk away recently
John: well I probably have got more courage than I did years ago and stand up for myself
NP: mmm
John: and people used to tell me, my wife used to say are you going to let them walk all over you
NP: mmm
John: what can you do? if he is a person who is nice and steady and he tells a story then you listen to it
NP: mmm
John: that is the way I er, you can't win them all
NP: have you ever noticed that people don't seem to understand or believe what you are saying
John: well [laughs] I am not too sure about that, well I don't know, funny enough now you mention it, I met a bloke last night, yesterday
NP: mmm
John: a big tall lad, lovely lad and he believes in this… whatever it is, his mother and all the family and he took me home [laughs]
NP: mmm

John: and I stayed there, that's where I was this morning [laughs] and they have a three, three of them really sick in the room
NP: sorry they have a what?
John: three of the family
NP: oh three of the family
John: dying nearly, don't worry about that, he says, you are here [there are three other patients in the same bay]
NP: mmm
John: so they gave me breakfast and talked away and I said [inaudible] and that's where I was
NP: so do sometimes other people not understand or believe what you are saying
John: I suppose they don't, I have never asked them, I suppose they think that I'm making it up
NP: so
John: may be at times I do, I don't know, that is another thing, I don't, I don't think I do
NP: no
John: no as I say I am not that type of person I tell the truth and if something happens I tell it
NP: so do you think that by in large people understand what you are saying
John: well if they don't want to maybe [laughs] I don't know. My sister laughs
NP: mmm
John: they think that you are getting mixed up
NP: mmm
John he is back again looking in to see if you are still are, do you know him?
NP: yes he is one of the nurses here
John: oh he a nurse as well?
NP: mmm
John: and a farmer
NP: um do people, do you think people always believe what you are saying
John: well I don't know, I suppose I will find out, sometimes I find it bloody funny [laughs] myself, you know, things happen that you wouldn't think would happen
NP: right
John: and people won't, people won't believe you
NP: so you mean sometimes things happen that you would find it hard to believe
John: of course, but I wouldn't talk about it much because they will only laugh at you anyway
NP: mmm
John: I mean what is the use any way
NP: mmm
John: I tell people close to me, like my sister or someone like that, I tell them the crack and they say "Jesus you must be bloody mad where did you hear that?"
NP: can you tell me an example of one of the things you find hard to believe?
John well I cant think of it off hand, I might think of it in a minute, you see things happen out of the normal way of life
NP: mmm
John: and somebody comes along and says look at that fella, this happening and the other is happening
NP: mmm
John: and before you know they are on the [inaudible] saying poor fella there is something wrong with him
NP: mmm
John: there might be nothing wrong with him

NP: mmm

John: who am I to say, it is like you saying to me now, you are saying in your own mind “I wonder whether that fella is the full shilling” [laughs]

NP: mmm

John: you see

NP: do you think that I am thinking that?

John: could be

NP: mmm

John: but that is what you are paid for

NP: mmm

John I mean course it is

NP: mmm

John: and my sister says to me the other day, I says you were out, and my sister said “he is a nice enough man” but the words I said were “I don’t know, he asked me questions that is all I know”

NP: mmm

John: well it is true isn’t?

NP: sorry who were you talking about?

John: my sister

NP: oh

John: my sister says “what type of man is he?” or something like that, and I says “he’s alright, he asks me the questions and I give him the answers the best way I can” and she started laughing and I said there is no point in laughing about it, things happen

NP: and who is she talking about

John: you

NP: oh she is talking about me

John: yes, she is saying blah, blah, she must know you better than I do, does she know you?

NP: um

John: may be she has seen you I don’t know, she is a nice enough woman, yeah, yeah she grew up with me, you know

NP: mmm do you ever think that people sort of stop listening to you, stop thinking about what you are trying to say?

John: the whole point about it in life, in never, I am talking to you now, he is looking in and [inaudible] [laughs] the way I look at it is I tell my story

NP: mmm

John: if they don’t believe me

NP: mmm

John: I can do no more about it, because if you dwell on it

NP: mmm

John: you will finish up in the nut house

NP: right so you mean if you dwell on people not listening to you?

John: yeah, yeah if you are in a group of people and somebody says blah, blah, blah and they say what do you think about it and I say well I give that reason and they say that is not the reason. Well it is no good me talking is there

NP: mmm

John: because you are not going to convince a whole crowd of people are you

NP: mmm

John: and sometimes you won’t be able to convince one, so why get yourself in such a state?

NP: right

John that’s my way I do it and sometimes my sister kind of goes into a boom, boom, I just stay quiet and walk out and kind of just come back in and everything is back you know

NP: mmm

John: because it is no good arguing

NP: yeah
John: no good
NP: so do you find that people don't believe what you are saying so you would get into arguments?
John: sometimes, sometimes well I won't get into it because most times I walk away, I say I am sorry I can't cope with it
NP: mmm you say that?
John: yeah I say that many a time
NP: and what is it you can't cope with?
John: well I can't cope with what they have come up with, the answers they want, and I'm not going to tell lies for the sake of telling them
NP: mmm
John: no why should I?
NP: can you
John: and one thing that my sister and other people say is "there is no need telling lies when you can tell the truth"
NP: mmm
John that is it
NP: mmm can you think of a recent example where that has happened?
John: a lot of things have happened, places that I've, I can't, not really. I think him now, him there for instance, his own house last night, "you can stay the night" and all this
NP: mmm
John: fucking getting on my nerves,
NP: mmm
John: he is making it out like he is the big fella, probably in other people's eyes he isn't
NP: mmm
John: but to me yeah, so I say I'm going home, "how are you going to get home from here"
NP: mmm
John: well to be quite honest I don't know what happened now
NP: mmm
John: whether I got left it or what, he probably wouldn't let me go anyways, but I don't remember so my sister said to me how did you get on with him I said "he is a thick so and so,"
NP: mmm
John: to me he is anyway. I am not perfect myself so I am only giving my side of the story
NP: when you have been in situations where people seem to not be quite believing what you are saying what, what's that like for you?
John oh if you are telling the truth and someone doesn't believe you, I think it is one of the worst… walk away
NP: mmm
John: because they will laugh you out of it
NP: right
John: in my opinion
NP: mmm
John: and I have seen it, I have seen men knocking hell out of one another
NP: mmm
John: for nothing
NP: and why is it that you walk away?
John: why should I get myself into it, they are not going to believe you
NP: mmm
John: and why are you trying to make them believe you, you can't do it
NP: mmm
John: they will laugh at you

NP: and why are they not going to believe you?

John because they think you are not telling the truth or whatever the situation is, they say "he is so and so and blah, blah, blah," I know them, I heard them saying it about people, maybe about myself as well, so the only thing you can do is, go with the flow and that is it. I mean, they will be there when I am gone, or maybe I will be there when they are gone

NP: mmm

John: actually a bloke told me one time the best thing you can do in an argument is walk away

NP: mmm

John: but it is not easy to do

NP: mmm

John: if you think you are right [inaudible] even the policeman might also think that you are wrong

NP: mmm

John: but surely you are not going to give in to him, I wouldn't

NP: so just before you walk away what is that moment like then, what is going on then

John: well I've lost the game really but at the same at the same time I feel that I haven't told any lies or anything so he might feel like he has won, maybe he has, but at the same situation I have gained as much ground I think [coughs]

NP: do you think they are telling lies?

John: well I wouldn't say so, some of them might I don't know what the situation might be, you can't tell what kind of people they might be, they probably look at me the same way

NP: mmm

John: you see, you see, I know people who never stop lying, all the time and you know it, day one, Jesus what is he doing keep walking in here all the time,

NP: he is a nurse

John I know [laughs]

NP: it's his job, it's his job

John: I wouldn't think that he is a nurse, you want to see the size of the house, were you in it?

NP: no [laughs]

John: oh Jesus

NP: and um so do you feel that people are accusing you of lying really?

John: well I don't know, I never ask them and if they do you can't do nothing about it

NP: mmm

John: all you do is state your facts, sometimes me and my sister might have a little argument, she would say so and so and so and so and I would say the opposite, and everybody is on a loser

NP: so what kind of things do you disagree about?

John: I don't know normal things, like buses, talking about buses, more back up in London I think or something like, in my case, drink

NP: mmm

John: if she says to me have you been drinking I would say no I wasn't [laughs] but she can smell it and she would say "have you been on that fucking drink again?"

NP: mmm

John: I have had a couple of pints and that is it

NP: and what would be the disagreement about buses

John I don't know, it would come like what the situation would be um going on the bus or is she on it? You see people start arguments or discussions
NP: mmm
John: but sometimes people will make it that way, I won't
NP: mmm
John: because I won't cause an argument, and I think that is my problem
NP: mmm
John: that people will walk all over you
NP: mmm
John: cos I am too damn quiet
NP: mmm
John: anyway, I am what I am [laughs]
NP: are you unsure now of anything you used to be sure of?
John: well the way in my life was, I done the best I am not [inaudible] I might work, I done the best I could, that is it. But people will come anyway no matter what you do, even your own family will say God you made a bad job of this, so you either take it on the chin and walk away or have a big argument, and with my family I try not to, just brush it over you know
NP: so like um memories you know or facts or things that have happened to you are you less sure of?
John: that's a mate of yours there
NP: yes he is one of the doctor's yes
John is he a doctor an' all? [laughs] he'll lock me up and throw away the key
NP: [laughs]
John: but I tell them the truth
NP: yeah are you less sure about things like memories, facts or things that have happened?
John: I don't dwell on it
NP: but
John: if I dwell on it
NP: are you less sure of it
John: I suppose there are less things I am sure of yeah, I don't suppose anybody is 100% sure of what happens
NP: mmm
John: no because people can tell lies, I can tell lies probably too as well if you look at the other side of it, my sister always says to me "look at the other person"
NP: mmm
John: you knows
NP: so you've doubt things now that you didn't used to doubt?
John: of course I doubt things
NP: like
John: like things that have happened, was I right was I wrong?
NP: mmm
John: but then again if you dwell on that… you see the whole point of this is, dwelling and thing um you would never do anything
NP: mmm
John: if you won't do something what are you? You are nothing,
NP: mmm
John: that is the way I look at it, if you don't see a bloke who gives you a job then you try do the best you can
NP: do you doubt your memories now in a way that you never used to? You know you tell me these things that have happened
John: yeah, yeah, of course I do, but then I look at other people [laughs] and they are a lot worse than I am, for telling lies and this, that and the other
NP: mmm

John: two faced lies, sometimes the good man, um, um, the bad man gets the best and the good man doesn't. Now when I say good he is telling the truth blah, blah, blah and the other bloke is making a liar of him

NP: so do you feel just as sure of your memories now as you always have done?

John: no, no

NP: like for example thinking about last night

John: yeah

NP: were you just as sure of all those events last night?

John: well I'm not a 100% neither

NP: mmm

John: if a judge asked me I would give him the best what I could do [inaudible] [laughs] shake the bag

NP: did you used to be 100% though on things that happened to you?

John: I was, I was more when I used to be a young man I knew what was happening and I stood up, my wife used to say "don't let them walk all over you"

NP: mmm

John: she wouldn't [laughs]

NP: and do you feel now that there is more uncertainty about these memories?

John: oh I suppose there is, and that's why another [inaudible], another thing that you must realise is that if you are uncertain you won't go into it

NP: mmm

John: you would let it go

NP: mmm

John: but you're no better off [laughs]

NP: and do you do that?

John: sometimes I do

NP: mmm

John: well I do with my sister

NP: mmm

John: there is no good arguing with her because you will cause a big fucking uproar and the next thing she will be crying in the bathroom or whatever

NP: so sometimes people with memory problems have a symptom we call confabulation

John: yes, what is that?

NP: it is where they tell stories to fill in the memory gap if you like

John: yeah could be, could be. I don't know that I am doing that, maybe I do, maybe I do, I never looked into it, but I can tell a good story [laughs]

NP: [laughs]

John: laughing or something anyway, but I don't know

NP: so do you um if you are doing it do you have any awareness of doing it?

John: I suppose I do, if I am telling it then I know that I am telling it, and the only way I wouldn't know is if I was pissed drunk [laughs]

NP: so when you tell me these things are you always, can you tell the difference between the ones you are less sure of and the ones that you more sure of

John: no, no I don't think so, you wouldn't be in that situation if you could [laugh], no I wouldn't know it. Bloke could be telling a two faced lie, you can see it sometimes, but, you don't bother him let him get on with it

NP: and can you tell the truth, the difference between things that have definitely happened and the things that you are maybe less sure of?

John: to an extent I can. If it is really happening and it is important I will tell what happened

NP: mmm

John: but then again, I suppose a lot of people walk away and say nothing

NP: mmm

John: and they are probably better off, but if I was working for crowd of people or in a factory or anything, what I'd seen I'd seen, um, what I'd seen I'd say, that is all you can do

NP: and what do you mean working in the factory

John: um, well if you worked in a factory and something happened and the governor said "who caused this?"

NP: mmm

John: well, you are going to tell them

NP: so why did you mention the factory?

John: it is only for the example, it could be anywhere

NP: mmm

John: something could happen in here, and I'd seen it, maybe he comes and asks me, the governor whoever he is, "did you see it happen?" Well what are you going to do? You are going to say you're telling lies if you don't, and he might have you anyway, he might know, so you tell the truth

NP: mmm

John: you are going to hurt somebody, but it is better that you tell the truth

NP: mmm

John: that is my opinion, I can remember my parents saying to me "always make sure you tell the truth"

NP: you seem very concerned with sort of truth and lies

John: well it is very important

NP: yes

John: cos my kids I used to tell em, tell the truth

NP: have you always had this concern with the difference between truth and lies

John: yes I have, you see we were poor

NP: mmm

John: and you fought to get that bit up, and you didn't want people coming and saying "look at them they have nothing," you let them know that you have something, you see and that is pride. My granny used to say to me "don't let them take [inaudible]" [laughs]

NP: do you think that it is the same with your memories

John: it could be, it could be, but it is a bit bloody late in life to find out now isn't it [laughs]

NP: I guess what I mean is, sorry you are crying

John: no it's, it's built up [inaudible] anyway I don't mind [laughs] I am what I am

NP: what I mean is, do you think that some of the, do you ever, are you ever covering up your memory through embarrassment

John: I could be I never even looked at it, it could be, but normally I'd sooner if I see an argument I will walk away

NP: so it is not something you are aware of doing

John: no

NP: covering it up

John: no, no

NP: because of embarrassment

John: no I wouldn't, I always walk away than sooner get into an argument, cos it is a waste of time

NP: yes, um I mean embarrassment though do you

John: it doesn't embarrass me

NP: this happened last night

John: yeah

NP: because of I don't want to admit that I can't remember what happened

John: yeah I know what you mean, it is not easy to do

NP: mmm

John: it is just one of those things that life is, somebody has got to do it, my sister used to turn around and say to me "you know you were out walking miles away and the police had to take you home" and I am saying to myself "I don't remember a bloody thing [laughs]"
NP: mmm
John: it's true, I don't remember
NP: but how does that feel when someone tells you something like that?
John: it hurts
NP: mmm
John: well whether you would say your fucking head has gone
NP: mmm
John: yeah or going, but it just happens to a lot of people at my time of age of life, but my sister says to me, which is right I think, "just go along, don't get excited," everyone makes mistakes, it depends on how big they are
NP: mmm
John: I don't bother anybody, fucking bother myself [laughs]
NP: mmm
John: but anyway
NP: did you make any mistakes?
John: thousands, thousands,
NP: like what, what kind of mistakes?
John: I don't know where to start, I made mistakes through school, telling lies which every kid does
NP: mmm
John: and all them things, but when I got grown up and all them things there, you begin to get more human [laughs]
NP: mmm
John: you, you go along with a crowd of people, she was going to come in she has gone away again [laughs]
NP: ok listen we are coming up the end of the interview
John: thank God for that [laughs] Jesus how long was that an hour? [laughs]
NP: yes just under an hour, 54 minutes
John: it is like a mad house here
NP: they know that I am doing these interviews
John: see if you can see my sister and tell her
NP: I am going to see your sister yes
John: yes tell her I am here
NP: yes
John: and I don't know where she lives
NP: mmm
John: and I can't go home
NP: mmm don't worry we are going to get you back to your sisters
John: good
NP: um what was it like being interviewed about this stuff?
John: no I don't mind it I feel good
NP: mmm but it was upsetting at times?
John: of course it is upsetting, but I can tell the truth
NP: what was upsetting?
John: well I don't know, all life, if you have to tell things that you don't want to tell, well I didn't have to tell that much there I was only telling you what I believe in
NP: mmm
John: the truth is the most important thing I was always told about it, not that I went all the way with it [laughs] you know, but a man is a man whatever he may be
NP: mmm [laughs]
John: yeah and what you did to me now um I do my best
NP: yes shall I end the interview there then

John: oh indeed yes, sometimes the best isn't good enough

NP: mmm [laughs]

[End of Transcription]

K. CATH'S TRANSCRIBED INTERVIEW

NP: ok so that is it recording um can you tell me in your own words why your brother is being seen in the hospital, um why, why do you think he is in the hospital?

Cath: well I think it, it is from drinking, smoking and he has picked up an infection in his lungs and he had a big operation in Barts Hospital for Prostate

NP: mmm huh

Cath: and that has something to do with it, but I think the drink has mostly drove him this way with what he is doing

NP: mmm and when you say this way, what is he doing?

Cath: I mean running away and when he hasn't got the drink or he hasn't got the money for it

NP: mmm huh

Cath: just going, walking away because he can't live without it I think, but he stopped drinking for seven years

NP: mmm

Cath: but went back on it

NP: mmm

Cath: and I think what made him go back onto the drink, is his son took him to his wife's grave, because he put a stone on it, because his wife died very young

NP: mmm

Cath: and left him with little small babies and little small kids, so he had to quit work to rear them and that had a lot, he went back, he never used to drink, in his young time he never drank, he was a teetotaller

NP: right

Cath: it was the death of his wife

NP: right

Cath: in 69

NP: gosh that was

Cath: in this hospital

NP: right, you mentioned on the way here that your brother has been saying things

Cath: oh yeah

NP: that you found sort of unusual, you know

Cath: he has been everywhere

NP: mmm huh

Cath: a ship that sank and he got saved, he has been working in an office in the West End and two women locked him in and he got out of that, he has been, he's been everywhere, which I think is the Titanic it is in his mind, you know him thinking it's the Titanic

NP: mmm huh why do you think, um do you think that he is saying all these things, are you saying that these things haven't happened as far as you are aware none of these things

Cath: I can't say that it hasn't happened because I haven't been in England as long as him you know and he has been here longer than me, so I can't say that things haven't happened to him in his life, that he got locked in a room in the West End when he was working or something or maybe not in the West, maybe not even working

NP: mmm

Cath: but he did work in, he was a security guard

NP: right

Cath: and he worked in a bar in um The Barbican, he went back to the Barbican
NP: mmm huh
Cath: he went back to places where he used to be
NP: you mean when he went walking
Cath: yeah
NP: when he went wandering and got lost
Cath: yeah he went back
NP: right
Cath: where he used to live and where he used to work
NP: mmm
Cath: he went back to them places and then he went looking for his kids which were grown up and married but he thought they were still little
NP: mmm huh what is your understanding of the problem?
Cath: it's um his mind lapses
NP: mmm huh
Cath: sometime he could be, now he is not, but as long as I have known him sometimes he lapses but then he would be alright
NP: mmm huh
Cath: and then maybe in the evening he has gone back to the same thing again, he could be fine in the morning
NP: mmm huh
Cath: and know everything and in the evening he will be in a different world again
NP: right
Cath: completely a different world he told me various things, like he had been in a farm house the previous night when I knew that he has been in the hospital
Cath: yeah he does say, he has these, when he was in Bart's he says that they took him away to a train station on the bed and left him at the train station, the hospital, Bart's hospital
NP: yeah
Cath: you see and then another time he says they locked him up on a roof, when he was in the hospital
NP: mmm huh
Cath: cos he had a lot of morphine in Bart's
NP: right
Cath: because he had very bad illness cos he almost died in Bart's
NP: right so when was this?
Cath: it was a few years ago now
NP: right
Cath: and he had a priest in the middle of the night
NP: so when he says these things now, is it very similar to how he was then?
Cath: yeah
NP: before?
Cath: yes he told me now, he told me he is not in hospital
NP: mmm huh
Cath: he says I'm going to find a place, I'm going to find another place to live, another place out of here, he doesn't even know that he is in the London hospital
NP: mmm huh
Cath: you can ask him and he will say yes, but a few minutes after he will say no
NP: why do you think that he says these particular stories, about being on a ship?
Cath: I don't know what comes in the mind, they say that you go back to the past, that is what granny used to do, granny used to go walkabout

NP: mmm
Cath: but because we live in Ireland, in a small community, that people were there if she walked, say she walked out of the house, there was the next door neighbour and thing and they would bring her in
NP: mmm huh
Cath: it is not like here
NP: mmm huh
Cath: you know when you are in a small community, the community know you
NP: mmm huh
Cath: so therefore they look out for you
NP: mmm huh
Cath: but here it is not like that
NP: um do you think that they relate to previous things that have happened to him?
Cath: I think it is, yes, I think it relates to… in his life being brought on
NP: but why do you think he is talking about these things now, what, you know, why do you think he is?
Cath: er because he is not, he is um not living in this time now
NP: mmm
Cath: he is living in the past, he is living in the times when he was growing up, when he had his kids, cos he things his kids are all little, his daughter was in today
NP: mmm huh
Cath: Leah was in today and he thinks that they are not, that they are not, he thinks that his kids are all small, he doesn't know me sometimes and I, I am so close to him, I do everything
NP: and he doesn't recognise you?
Cath: no, sometimes he doesn't know me
NP: why do you think that happens?
Cath: I don't know, part of his, I think they done an x-ray and part of his brain there is something wrong with part of his brain
NP: so is that what the doctors understanding of the problem is as far as you know
Cath: yes
NP: they think it is to do with the brain
Cath: yes it is to do with the brain, cos he said part of his brain there is something wrong but because I am not a doctor I don't know what he said
NP: do you agree with that
Cath: yes
NP: you think it is
Cath: the drink, he used to be such a heavy drinker
NP: mmm
Cath: and then he stopped it for seven years and went back on it and he went back on it much worse than before
NP: with these problems with him saying these things that have happened to him, what, what, when did you first notice the problem with this?
Cath: quite a few months ago, when he, the first time he went missing, when Bert his son took him to the graveyard, to his wife's grave and put the stone on it, it all seemed, he changed completely, he just changed. And I still say it was going to the graveyard that changed him because in his mind he is going to go there, and he has been trying to go back there ever since
NP: and why do you think going to the graveyard changed things
Cath: because I think he knows that he is going to go there
NP: mmm huh
Cath: because that is where he is going to be buried with his wife, so I think that it is all in his mind

NP: right but, so do you think that this is him choosing to go to the graveyard
Cath: yes, I don't think that he is worried about dying
NP: mmm
Cath: because he has not eaten, he won't eat I have tried, I try everything, I have tried so much
NP: so do you think that it is to do with changes in the brain
Cath: yeah, it is his brain
NP: or do you think it is to do with wanting to
Cath: it is both, it is both
NP: right
Cath: I think going to the graveyard, cos he shouldn't have gone to the graveyard
NP: mmm
Cath: I told Bert you shouldn't have took him, cos it makes him think now that he is not well, he is not worried if he dies, you know he doesn't worry about that
NP: right
Cath: and if he doesn't eat soon, he has got no, he has lost so much weight, Ollie has said that he has gone down to nothing
NP: when he was beginning to sort of say odd things, how did you know that they were odd things if you see what I mean?
Cath: yeah I do know that they are odd things he talks
NP: and how do you know that?
Cath: because I am so used to him I know, I know the way he is… when he is alright he is fine, he is cooking, he is a great cook, he is cooking he is doing everything and he looks after himself when he is well, he is not now
NP: and in terms of him saying the funny things
Cath: yeah
NP: how do you
Cath: he is saying all these weird things, perhaps he has been through them things I don't know about
NP: mmm
Cath: I know when he was growing up that he was a problem for my mum, and I know that he was put in a school and he can tell you everything about that, even his mind is not… right for this time, but he knows all about them times
NP: mmm huh
Cath: he knows what school he was in
NP: mmm
Cath: if you give him something to add up, or er he can add up like nobody's business, and take away
NP: mmm
Cath: and do everything
NP: mmm
Cath: but I think he was sent and put away in the school… and maybe that
NP: and do you think that that is having an affect now
Cath: yeah I think so
NP: what makes you say that?
Cath: because he was probably he, he thinks that why was he put away
NP: mmm could you think of a recent example where your brother said something and you didn't really understand why he was saying this?
Cath: now I don't understand why he is saying things but before I used to know everything he used to say
NP: can you think of a recent example I just want to focus on a recent example can you think of something he said in the last few days that you

thought was a very strange thing, maybe the ship, did he say that recently?

Cath: no

NP: what, what has he said recently like that?

Cath: he went to the park with this kids, with his small kids and they were in the park, this he just said this to me on Tuesday

NP: mmm

Cath: I have been in the park with the kids

NP: mmm

Cath: and his kids are all grown up

NP: mmm huh

Cath: his kids are not little

NP: I just thought how did you know it was a strange thing to say

Cath: it is a strange thing because really

NP: but how did you know that, I know that it maybe seems an obvious question but

Cath: yeah it is

NP: but how did you know that, what was it that made you go well obviously that is not true

Cath: but you can't say that to him, that it is not true

NP: mmm huh

Cath: because he thinks that it is true

NP: how are you so sure that it is not true?

Cath: but I am sure it is not [laughs] I know that is not true [laughs] because his kids are grown up and living in Claxton and Chelmsford and Kent

NP: right

Cath: he doesn't know Bert, his son when he comes

NP: mmm doesn't he?

Cath: he has to be there for a while and then he'll gradually know

NP: right so he doesn't recognise you as well

Cath: no sometimes he recognises me, and sometimes he won't recognise me

NP: mmm huh

Cath: he doesn't know that he is in hospital

NP: do you always understand what he is saying, you know

Cath: I know, I understand what he used to say

NP: mmm huh

Cath: but not what he says now, cos he is in a different world

NP: and what do you mean you don't understand it, what is it about not

Cath: like he is like he is not living where he is living

NP: mmm

Cath: it is not his place, I am not going to be living there

NP: mmm

Cath: like when he goes, when he comes in hospital, he is not in hospital, this is not a hospital

NP: so it is because you know that these things are not, is it because you know that they are not true

Cath: yeah

NP: you know that they are not true therefore you don't understand it

Cath: I know he never used to be like this

NP: mmm

Cath: I know for sure he was a man that used to clean his house

NP: mmm

Cath: cook his food, buy his shopping, because he used to look after kids in his time, I mean his wife died and left him with one, two, four boys and two girls

NP: why do you think

Cath: he lost a little baby too when she, um for a few months um when she was born with pneumonia

NP: right
Cath: he often mentions that
NP: he does
Cath: mmm
NP: why do you think that he is saying these things, why do you think that he is talking about all these things?
Cath: I don't know, I can't get through, he is just that he has going back, he is going back to the past
NP: and why do you think that he has done that
Cath: I don't know, it is hard to know isn't it? Because you can't get inside their mind, inside their brain to know these things
NP: mmm
Cath: only they know… and they know that they are living in that time, they are not living in this time now they are living in the past
NP: mmm
Cath: which is true, I suppose you can live in the past and go back to the past… but he is always running away, why is he running away? because he had a nice flat, I am there I cook for him, I do whatever I can, but it is not enough somehow
NP: why do you think that he is running away?
Cath: that is what I don't know why is he running away, did he always run away
NP: mmm
Cath: he couldn't have cos he was married and settled
NP: mmm
Cath: so he couldn't have always been, he was a worker he worked, even when he had his kids he paid a woman to look after them to work and go to work
NP: right
Cath: so he wasn't running away then
NP: mmm
Cath: so I don't think it is anything to do with, I don't think he has ever ran away, because when he left the school where he was he went to work with a farmer
NP: mmm
Cath: and he met his wife in Mayo, he met his wife there and they came to England and got married and she was a very settled woman she could keep him without the drink, he didn't drink
NP: mmm
Cath: but I know that at weekend she might say you can go now and have the drink
NP: right
Cath: but she would take the money, she was very um he couldn't rule her
NP: right
Cath: [laughs] she was a good woman
NP: and do you think that
Cath: that, that has affected him really
NP: mmm huh
Cath: losing her young
NP: yeah
Cath: she used to work in the hospice, and she was, she was a good woman. I mean if you lose your wife and you have all them kids
NP: mmm
Cath: you can't be right
NP: mmm
Cath: to look after a little baby just born
NP: that must be tough, that must be
Cath: and that is when he started the drink

NP: right. Does he ever explain what he means by these things when he says these sort of things he says that you don't quite understand

Cath: he will tell me I don't understand, he will just tell me that I don't understand [laughs]

NP: he'll just say you don't understand

Cath: yeah

NP: he doesn't explain himself

Cath: no but he is very moody, he is moody today

NP: mmm

Cath: he is very moody today and his daughter has not long gone, and he didn't even know her, he didn't know his own daughter

NP: mmm

Cath: and his grandson

NP: do you…

Cath: he will go, he will um when he was back at this flat from being in the hospital, he left the hospital didn't he

NP: mmm

Cath: when he came back in his flat the first time he was never settled, I don't want to be here, this is not my place, I need to go to my other place

NP: aah

Cath: so I says to him you haven't got another place, he says yes I have, I have another place and this is what he is going looking for all the time, this other place, his other flat

NP: mmm

Cath: cos that is what they do

NP: but why, why do you think he is saying talk about another flat

Cath: because he thinks he has another flat

NP: mmm

Cath: that is in the past, he went to XXX buildings cos he used to live in XXX buildings

NP: right

Cath: so we told the police he has probably gone to XXX buildings to see his kids, so he did go to XXX buildings and was walking back from Whitechapel

NP: right

Cath: and the manager of where we live found him in Whitechapel

NP: mmm huh

Cath: and brought him back and bought him a cold drink and brought him back home

NP: when he says these things about being on the er can you tell me actually about this

Cath: ship

NP: yes about the ship can you tell me what he said about that

Cath: he said he said he was on the ship and the ship sank and all the, and all the people was gone and he got saved, how he got saved I don't know he didn't say, but he said he got saved… from the ship

NP: mmm

Cath: where that came from I will never know

NP: and when did he tell you this

Cath: the first time he went missing

NP: right

Cath: the first time

NP: so that is a couple of months ago

Cath: yeah, no that is about seven weeks ago

NP: a couple of months, seven weeks

Cath: seven weeks

NP: yes

Cath: it is not even two months
NP: right, yes um and
Cath: and he got saved
NP: can you remember where you were when he told you this
Cath: I was down with him in his flat
NP: mmm huh
Cath: sitting with him in his flat
NP: mmm huh and how was he at the time
Cath: serious
NP: mmm huh
Cath: very serious about it, that it really did happen
NP: mmm huh
Cath: it really did happen, even being locked in the offices in the West End, very serious, it really did happen, two women locked him in these offices [laughs]
NP: and did you try and persuade him that it hadn't happened?
Cath: um I told him, no I didn't try too hard you know because it is not worth it, because he would still be angry with me and say it did happen you know
NP: mmm huh
Cath: sometimes if you kind of disagree with him, he won't like that
NP: right
Cath: he don't like you to disagree with him
NP: mmm
Cath: because he will be right, I, I told him that you are in hospital today and he said no I am not in hospital
NP: sticking if I may with the time he told you about the ship, what was your initial response to that, how did you feel?
Cath: well I thought it is not true, you can't think that is true
NP: why not?
Cath: [laughs] I could never think that he was on a ship [laughs] and everybody died and he got saved [laughs]
NP: mmm
Cath: that would be a miracle
NP: mmm and how did you feel when he told you?
Cath: he said he was working on the ship [laughs] and got saved
NP: mmm
Cath: but he never worked on a ship I know that
NP: he has never worked on a ship
Cath: no, never, but years ago when he came to London, I suppose, before, he was here long before me there were [inaudible] ships or something, they were funny ships or boats you know, so he has probably got something in his mind about a ship, but I think the Titanic is in his mind, maybe he was on a Titanic in another life [laughs]
NP: right
Cath: maybe he had another life [laughs]
NP: and [laughs] why the Titanic, why would you think the Titanic [laughs]
Cath: because he has heard so much about the Titanic by the television, you know by the films
NP: right
Cath: and maybe he thinks he was on the Titanic [laughs]
NP: has he ever particularly interested in the Titanic
Cath: he is interested in films, he is interested in the old films, you know the old things that happened yeah
NP: so has he spoken
Cath: history, history
NP: has he spoken about the Titanic in the past?
Cath: no more, um his type of films is cowboy

NP: mmm right ok
Cath: its cowboy films [laughs] because in Ireland he used to go to all the films, you know wherever he would have done a job he would save to go to that pictures, because it was only pictures, in Ireland there wasn't everything that they have now when we were growing up
NP: and did you think that this interest in films
Cath: yes he was very interested in films
NP: but do you think that that is to do with why he is saying these things
Cath: yes, he loved the old films
NP: mmm
Cath: old films he would follow
NP: so are you saying that he is mixing up films and his own life?
Cath: I don't know
NP: no, so you are not saying that
Cath: because he was alright, I wouldn't think so
NP: right, how did you feel when he said I have been on a ship and it sank, how did you feel about that time, when he said that?
Cath: no I just thought, how can you say that you were on a ship and the ship sank and everybody has gone but you are still here
NP: so
Cath: well he says, I, I was. But you can't say to him you wasn't you know
NP: did you immediately know
Cath: I knew it wasn't true
NP: immediately
Cath: I would know that that is not true, I would have heard something about it, if it was true, before now
NP: mmm
Cath: because it wasn't true and when, I can't say about the offices, because you know if you worked in offices they could go home and accidently lock people in offices, you know it has happened
NP: yes, so with the ship you knew
Cath: no I don't believe the ship
NP: you don't believe it
Cath: no he wanted to go to, he had signed up to go to Canada
NP: mmm
Cath: before he met his wife and then when he met her, she decided no and I think that affected him because he did really want to go to Canada because he had a place there
NP: mmm
Cath: and he was the type to stay there and send for her
NP: mmm
Cath: because he wanted to go to make everything, he was quite, very interested in going to Canada when he was young, so that wasn't…
NP: and do you think that relates to links about the boat
Cath: yeah he, she didn't agree to go
NP: mmm but how would that link in with the boat and talking about the boat sinking
Cath: no I don't think the boat um except if he had an accident in Ireland on a boat
NP: mmm
Cath: you know they go out on the water in Ireland on the boats and fish and do all sorts of things
NP: mmm
Cath: except when he was young
NP: mmm
Cath: and he went to that school

NP: mmm
Cath: I think he nearly drowned once in the school
NP: right
Cath: in the school he went to I think they took him out in the water and he almost drowned
NP: oh so there is something
Cath: it could be something like that
NP: is this a fact, so this did happen to him?
Cath: yeah
NP: are you sure about that
Cath: yeah he did, he nearly drowned in the school in Gallway, he was in Gallway, that is where he was in the school
NP: when he said this about the boat capsizing
Cath: I believe he was out in the boats in Ireland
NP: yes, you believe that, but when he said that recently, seven weeks ago um about the boat sinking, did you do anything to try and work out why he was saying this
Cath: no I asked him "when did it happen?"
NP: mmm
Cath: and when were you on this boat
NP: mmm
Cath: and he would just say yes I was on it and you couldn't argue with him because he is the type of person if you keep on asking him he would lose his temper
NP: mmm and were you asking him, were you trying to
Cath: yeah I wanted to find out
NP: you did
Cath: yes
NP: what questions did you ask him?
Cath: just where was he on this boat
NP: mmm
Cath: that sank and where was the other people
NP: mmm
Cath: and how did he get saved
NP: mmm
Cath: and he said somebody saved him, but somebody saved him um he did in Ireland nearly drown on a boat, um a not a big boat
NP: mmm
Cath: you know a small boat, and somebody did save him, from the school
NP: did that immediately come to your mind when he was saying this
Cath: yes I thought that was what he um that was in his mind
NP: and you thought that immediately
Cath: yes
NP: so you just thought that that's what happened in the past
Cath: in the past
NP: so you just thought this is… ok
Cath: yes because he did um he was on a boat, on them silly boats in Ireland
NP: so it sounds like you find quite a lot of sense in what he is saying
Cath: not now, not this last while, there is no sense in what he says in this last while whatsoever
NP: give me an example
Cath: well he is saying silly things, like he has been to the park today
NP: mmm
Cath: and his kids are small and the other day he went looking for his kids to see if they were alright cos they were little
NP: mmm
Cath: that does not, and um he lived in a flat that is not his flat and he doesn't live there, yet all his family is in front of him

NP: mmm
Cath: yet he doesn't live there
NP: so there is no, you feel that there is no sense to it
Cath: no, there is no give now, and I said look at the photos, look at your family photos, look at your wedding, your wife, he said "but I have got them in my other flat." This other flat, wherever it is this other flat
NP: you mean he has got his wife and his children in this other flat
Cath: and the same as the flat he is in
NP: yes, do you think that these stories change his mood at all?
Cath: sometimes he gets really angry, he has been really angry many times
NP: mmm
Cath: he nearly hit the carer one time
NP: right, right
Cath: the warden had to come down
NP: mmm huh
Cath: he gets angry and he can get very angry
NP: ok
Cath: and lose his temper and tell everybody to "go, get out"
NP: mmm
Cath: yeah he can get very, very angry
NP: what is it like having a conversation with him about these things?
Cath: but you don't, you know because it is just things he is saying you just say "yes" and "no," the warden told me because I don't say yes and no you see I try to get to know you know what, what is it, but the warden says you can't you just have to say yes, say alright, but I can't, I can't do that
NP: what are you doing?
Cath: I have to ask him [laughs] where is this? why did this happen?
NP: and why do you need to ask these things?
Cath: because I want to know, you know more about it, you see
NP: mmm
Cath: you never know a person, you have to know them deeper than just saying yes, say he said to me something now about being in the park, then I have to know why have you been in the park and which park have you been to
NP: mmm
Cath: but then the warden says "no, you just agree with him," but why should I agree with him?
NP: are you asking him questions to make him realise he is wrong
Cath: yes that he's not, that he hasn't been in the park
NP: so that is what you want
Cath: yes but the warden tells me no, you have to agree with him
NP: mmm huh
Cath: that you have to agree with him, but I don't think that I have to agree with him
NP: why do you want to persuade him that he is wrong?
Cath: cos I want to know, to get him trying to get him back
NP: mmm
Cath: in this life um in this time
NP: mmm and do you feel that you are able to do that?
Cath: sometimes
NP: mmm huh
Cath: sometimes yes
NP: and is that helpful for him?
Cath: yes, because he knows then what he is doing, he can get up then and make a cup a tea and he can ask me if I want a cup of tea
NP: mmm
Cath: you see when you agree with everything they say, they think their right
NP: mmm huh

Cath: but if you don't agree with everything they say they probably maybe in their mind say "oh, maybe I'm not certain"
NP: mmm
Cath: er something is not right
NP: mmm
Cath: but then the wardens try to say when I am with him in his flat, you know when he was saying all these silly things and I am questioning him, they tell me "no don't do that, you have to just agree with him." But why? I just say to the warden, "why should I agree with him?"
NP: what was it, what was it that made you realise that your brother is ill, that he has got this memory problem, what, what is it that made you realise that, can you remember?
Cath: yeah when I found out he was in hospital and they done this scan on his head, I knew that he wasn't quite well then, he was lapsing
NP: but was there
Cath: he lapsed
NP: but even before the scan did you not think
Cath: some days he was fine
NP: mmm
Cath: but I just took it to be, people can get fine sometimes can't they and they can, I can forget
NP: mmm
Cath: there are lots of things I can forget
NP: mmm so was it until the scan was done
Cath: yeah
NP: you just thought that this was just normal, this was just
Cath: yeah but he got worse
NP: mmm
Cath: but then do you know sometimes I could put somethings down and I would be looking for it and think where did I put it?
NP: mmm
Cath: because I read and I do more um he doesn't do them things. I used to try and get him interested in reading, you know in um doing these games, um puzzle games but he wasn't interested
NP: mmm
Cath: so if you don't keep your brain active, how are you, how do you think you are going to survive with real life?
NP: mmm do you do anything extra to try and understand what it is that he means
Cath: I've done most of the things that I can, questioning him
NP: mmm huh
Cath: trying to get him to… cook
NP: mmm huh
Cath: what he used to do, but he won't do it
NP: do you ever speak to anyone who might know him well to sort of try and
Cath: who? The wardens know him very well, he has been there sixteen years so, if they tell me I shouldn't, um if they say to me do you know sometimes too many people interfering can cause more problems for your brain
NP: mmm
Cath: you know when too many people, you know you have one warden today but you will have a different one tomorrow and in two days after you might have a different warden, you can't have different wardens telling you one thing and then you have to do another thing
NP: do you think that he uses words differently now
Cath: yeah but he will ask, um it doesn't matter who is there, it will always be me, I am the boss he says [laughs] he calls me the landlady [laughs]

NP: mmm

Cath: sometimes he is very happy and I can't help but laugh at the things that he has said

NP: is he calling you a landlady

Cath: he thinks I am the landlady of the whole building [laughs]

NP: mmm rather than his sister

Cath: yes

NP: right

Cath: he thinks I am [laughs] when the carers come he will say can you go and ask the landlady

NP: [laughs]

Cath: except if I am there the carers have no life

NP: mmm

Cath: but if I am there, he is fine

NP: right

Cath: but if I am not, there forget about the carers, they can go

NP: does he say anything that confuses you or surprises you?

Cath: no I know him very well

NP: mmm

Cath: before this and now

NP: and can you always understand the sentences that he is saying

Cath: yes

NP: you might not agree with what he is says, but can you always understand

Cath: yes, yes I know what he is saying

NP: so that is not a problem

Cath: no… but the problem is that I am not allowed to, which I do when nobody is listening, ask him things about where he has been and all these things he is talking about because they won't, you see I think in sheltered accommodation, they want an easy way, you know, and there is no easy way

NP: mmm

Cath: because it can happen to them, people don't think that… you see?

NP: does, does he say anything that doesn't seem logical to you?

Cath: well all the silly things

NP: mmm

Cath: but some days he could say something that is right

NP: mmm and in what way is it not logical can you sort of thing about that, what

Cath: um I know sometimes when he was at home in um when he wasn't running away, I would say to him are you going to peel the potatoes now for your dinner

NP: mmm

Cath: and he would say "alright" and go and do it and I would say "are you going to do your stew?" [he replies] "no you will do that," and I'd say "no you will have to do it." You know sometimes he would lapse you know he would lapse

NP: mmm

Cath: and he will forget and there is another time he would be cleaning and he would have his whole flat all cleaned

NP: mmm

Cath: he wouldn't want a carer

NP: right

Cath: he used to say to the carer "I clean my," because he always used to be good like that

NP: right

Cath: "I cleaned my flat" and then they would say to him "you shouldn't do that," but he should do it!

NP: mmm huh to keep active
Cath: because it keeps his mind and he has these flowers outside on his patio, he waters them and everything
NP: mmm
Cath: when I see him doing them things when I come down in the morning times to see him, when I see him doing that then I think oh well he is fine, he is fine now today
NP: yeah
Cath: he is going to be cleaning, he cleaned his windows before he went missing
NP: right
Cath: you see he lapses
NP: so it comes and goes, does he say …
Cath: but this time he has gone a bit far, whatever has done it, triggered to him, the drink
NP: does he say things that are illogical, things that don't make any logical sense
Cath: yeah the things he says now make no sense
NP: and how do you know
Cath: and he is very brainy you know, because he had the um you know in Mile End Hospital there is a um Sam who asked him all the questions you know and gave him things to do you know like counting, he could do everything
NP: mmm
Cath: he could do every single thing, he counted, he gave him numbers to count up, he could do it so fast
NP: mmm
Cath: you know because before computers we had to do things all in our brains in our minds
NP: mmm
Cath: when I worked in restaurants, I had to just do it
NP: mmm
Cath: if there was thousands, loads of people you just had to do it in your mind
NP: yeah
Cath: so he had to do that too
NP: do you think that when he is saying these funny things does he always mean something by it you know or do you think that it is just a lot of nonsense
Cath: sometimes he can play on it
NP: mmm
Cath: sometimes he can play on things you know
NP: mmm
Cath: to wind me up
NP: right
Cath: you know [laughs] he can play on things to wind me up
NP: right like what give me an example
Cath: you know, how can I say? he might say he has been somewhere this morning when I was out, and I will say you never and he will say you will but he was winding me up
NP: mmm
Cath: or he had been to the pub and he had been drinking cos he knows that I don't like drink, cos I can't stand drink
NP: mmm
Cath: cos I never drank or smoked
NP: mmm
Cath: and he knows to wind me up that way that he had been to the pub cos I never liked the drink

NP: mmm
Cath: cos in my family there is no, yeah my aunty and my uncle drank but not like er crazy drinking you know
NP: mmm
Cath: maybe they would start in the night but they would be together you know
NP: mmm
Cath: but not like er no um he drank too much
NP: right so you think that he always mean something though even when he is telling you about this ship going down, does he always mean something
Cath: well it seems to him he is serious with it, he seems very serious and the only time I can think of is when he was in the school
NP: mmm
Cath: when he almost drowned
NP: mmm
Cath: and one of the um the school, you know one of the teachers or the pupils, they saved him
NP: and why do you think that story is coming up now for him, do you think that that has got any relevance to his life at the moment?
Cath: he told me that he left the hospital here on er Monday afternoon, he told me that somebody died in the hospital and the police were in looking for the people that killed him
NP: mmm
Cath: now where did he get that from in the hospital?
NP: mmm
Cath: and that the police were here and that they were shooting and somebody was getting shot
NP: and what do you think he means by this when he says this?
Cath: that is what I don't know
NP: do you
Cath: I wish I could know
NP: and do you think that he means it just as it sounds, do you think he means to tell you exactly as
Cath: or did that happen in his life?
NP: mmm
Cath: did these things?
NP: mmm
Cath: but it couldn't have happened cos he married young but after his wife died in 69, I don't know how many things could have happen
NP: have you ever given up trying to understand what he means
Cath: no, no, I go down and sit with him to keep him company and thing, no I never, I never give up, no I just let him say them, they are interesting sometimes [laughs]
NP: [laughs]
Cath: them people, you see people think that them people are not well [laughs] in their own mind, they could say something and you just laugh at it [laughs] you know
NP: mmm huh
Cath: you see because in their mind they are right
NP: mmm huh
Cath: [laughs] but it can be funny sometimes
NP: has it changed how you think about other things that he says
Cath: well he doesn't say sensible things [laughs]
NP: he doesn't
Cath: no
NP: not anymore
Cath: no he used to, he used to, not now

NP: nothing,
Cath: he is worse now
NP: mmm [laughs]
Cath: but it is you see he has no weight on him, he is not eating, I have tried everything, he is not eating now
NP: how
Cath: but I mean you know people with dementia, they are in their own world you know
NP: mmm
Cath: they have, they have a world of their own and they can live in that world for a long time you know, dementia people, it doesn't kill them you know
NP: mmm
Cath: it is just that they could go out and get harmed
NP: and why do you think they are in this other world
Cath: why does the brain do this?
NP: mmm
Cath: it is the brain that you, I don't think that he was active enough when his wife died
NP: mmm
Cath: you see if you are not active enough as you get older you know your mind, it, it, you're not doing anything to help your brain to function
NP: do you think though that he is saying these things
Cath: oh he has been working on buildings he has been out working every morning
NP: mmm
Cath: he told me last week
NP: mmm
Cath: [laughs] they came and took me to work today
NP: do you think that he is saying these things, do you think that this world is a nicer place, the one that he is talking about?
Cath: no I think they are in a nicer place
NP: that is what I mean is that is why he is talking
Cath: yes, I think there is a nicer place
NP: mmm in what why is it nicer?
Cath: he doesn't worry
NP: mmm
Cath: nothing is worrying him anymore
NP: mmm
Cath: his kids, he thinks his kids are little, but they are not little, they are all grown up
NP: mmm
Cath: and he is not worried if he dies, he will tell you he is not worried about dying
NP: do you think that he chooses to live in this other world?
Cath: yes he is choosing it now, yes
NP: rather than it being the dementia
Cath: he doesn't want to be, he would rather be in the world that he is in
NP: mmm
Cath: cos that world is right, he thinks that world is right for him
NP: mmm
Cath: I mean my uncle has died and my aunty a long time
NP: mmm
Cath: and he told me when he went missing this time that he was with them, that he went to their house and he was talking to them
NP: mmm
Cath: and they are dead a long time
NP: so these stories are nice stories

Cath: they are past tense stories
NP: mmm
Cath: but they are not here now, but to him he was with them
NP: so are they nice stories generally
Cath: yes, yes they were good stories I suppose
NP: yes because you said a lot of the stories were quite interesting to listen to
Cath: yeah
NP: are any of the stories sad stories or bad stories where things go wrong for him?
Cath: granny dying, his wife dying
NP: is he talking about these things again? what I mean is the stories?
Cath: yes he is talking about them now, he is going back, he is going back, he has gone back… to when he was growing up, he has gone back to
NP: has he made, said any stories about his wife still being alive?
Cath: no he knows that she is dead
NP: he knows she is dead
Cath: he knows she is dead
NP: does he ever, these stories like the drowning one, like the
Cath: [laughs] sinking ship
NP: sinking ship one, does it always end well or does they sometimes end badly
Cath: well It ended well for him cos he got saved
NP: mmm and are they always like that
Cath: yeah when he was locked in the office he got saved again [laughs]
NP: mmm
Cath: so it seems that he always gets saved [laughs]
NP: mmm so they always turn out quite well for him?
Cath: yeah [laughs]
NP: do you think that that is relevant?
Cath: yeah, perhaps it is [laughs]
NP: mmm
Cath: if you listen, sometimes you have to just listen, you might laugh [laughs] but if you listen, he will tell you off for laughing [laughs] sometimes he will laugh as well
NP: mmm
Cath: he will laugh too, you see you can meet very contrary people and you can meet people where it is a laugh, it seems to be a laugh for them
NP: mmm
Cath: he used to laugh all the time
NP: mmm and he is doing that since
Cath: even when he is doing the wrong things [laughs] Jennifer, the warden, she would come in to see him
NP: mmm
Cath: and he would be talking all nonsense and she would be listening and he would be laughing
NP: mmm do you think that he knows that they are not true, these stories
Cath: no I think that he thinks that they are true
NP: 100%
Cath: I would say that he think that, I would say that he believes that they are true
NP: mmm huh
Cath: I don’t think he knows that they are not true
NP: mmm
Cath: he thinks that I am daft [laughs] because I don’t believe them
NP: do you think he er
Cath: he just stands there and says you can laugh [laughs] because he knows that when I laugh that I don’t believe them

NP: do you think that he is aware that he has memory problems?
Cath: yeah, you could ask him and he is aware yeah
NP: mmm
Cath: and he is aware that he doesn't want to live where he is living
NP: mmm
Cath: because he keeps going away and you know that he is very ill from his feet paining him and his legs
NP: mmm
Cath: from walking, and you think what we suffer from when he goes away
NP: mmm
Cath: thinking is he going to be alright
NP: mmm do you think it is now harder to predict what he will do or say than before?
Cath: he will go away, he will go away from this hospital even
NP: mmm
Cath: when he has only got them things on him, but they can see him now you see
NP: are you saying that it is harder to predict or easier to predict?
Cath: it is easy
NP: so you think that it is easy
Cath: it is easy because I know what is in him to keep going, he is searching for something but I don't know what it is
NP: and what about other um is it easy to predict all of his actions and behaviours just the same as you could before
Cath: yes
NP: you've not worried that I don't know what to do if?
Cath: because I know what he will do
NP: mmm huh
Cath: he will leave this hospital in London, the first chance, the first chance he gets
NP: and why do you think he will do that?
Cath: because he will because he is telling me today that he is not going to stay there
NP: mmm huh
Cath: "I'm not sleeping here tonight"
NP: mmm
Cath: and that is what, we at home are thinking "oh he has gone again"
NP: mmm and why do you think that he doesn't want to stay here tonight?
Cath: because he doesn't want to stay here in the hospital, he doesn't want to stay anywhere
NP: mmm
Cath: he doesn't want to stay in his flat
NP: mmm
Cath: he's gone, he doesn't want to stay in the hospital
NP: mmm
Cath: he will find some way of going
NP: mmm
Cath: and he has no clothes so he can't, but that won't worry him you know
NP: mmm
Cath: but he will go, he will, he has got to the stage that… he comes, he will be home for two days or three days and he will be gone again
NP: mmm
Cath: and you can't lock him in cos we are not allowed to lock him in
NP: mmm
Cath: and he will be gone, he will just go and he gets off, he takes off when the office is closed and he has gone

NP: and do you find it just as easy to understand his reasons for why he has done things, like you did before

Cath: you see um when he is home I bring him up in my flat and I make him his sandwiches or whatever he wants to have and he can watch his telly, cos I have a balcony and I am up on the second floor, and then the carer comes doesn't talk to him nice, "why are you here you should be down in your flat?"

NP: mmm

Cath: but he shouldn't

NP: mmm

Cath: he doesn't have to be down in his flat

NP: yeah he can be where he likes

Cath: and he doesn't like that you see

NP: mmm

Cath: because he was in the lounge, they have tea mornings

NP: mmm

Cath: and Jennifer and them were there and the carer came in and said "you know I am coming, why are you in the lounge?" and Jennifer said to the carer "no, you don't talk to him like that, he can come in the lounge, you can deal with him in the lounge"

NP: mmm

Cath: you don't have to tell him he has to be in his flat

NP: mmm huh

Cath: he doesn't like them things you see

NP: right he doesn't like being told what to do

Cath: he doesn't like to think that he can't, you see when you tell him you can't be in the lounge or you can't be upstairs, you can't do that because he is free to do what he wants to do

NP: he seems quite unhappy with people being bossy or

Cath: that is the carers

NP: right

Cath: not the wardens, he loves the wardens

NP: right but do you think that is relevant to his past, has he always been like that

Cath: well he was in a school

NP: mmm huh

Cath: he was in a school

NP: right

Cath: so he must have had to obey

NP: mmm and you think he doesn't like it

Cath: and he doesn't like it, you don't like to tell him what he can't do

NP: so he has never liked it

Cath: no

NP: what do you think about being interviewed about these things?

Cath: I don't mind, I will probably have to do it on myself one day [laughs]

NP: [laughs]

Cath: [laughs] probably… you never know do you, if it runs in the family, but you keep your brain, [laughs] I will make sure I keep my brain active

NP: mmm

Cath: I will do things and I will read and I will um but sometimes too much reading can do it too you know

NP: mmm

Cath: I am quite sensible in lots of ways I have grown up you know not an easy way

NP: mmm huh

Cath: but sometimes it is good to grow up a bit hard

NP: mmm why?

Cath: because you live and learn

NP: well ok
Cath: I am going to have to go back to him now
NP: I don't have any more questions do you?
Cath: but some of them women, them women on the ward
NP: the nurses?
Cath: some of them can be very rude you know
NP: mmm
Cath: and then he will take off, because when he took off on Sunday he told me one of them was nasty to him
NP: right
Cath: and he knows that, he knows that they were
NP: mmm
Cath: and that's why he went
NP: so that is one of the reasons for him going
Cath: yes and she stood there and let him put his clothes on and go
NP: mmm
Cath: why did she do that?
NP: ok
Cath: and the police said, you see the police said they are letting him
[End of transcription]